

068568 OCT

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

30205

1a DECEASED NAME (TYPE AND PRINT) JEAN D ADAMS		2a DATE OF DEATH MONTH DAY YEAR 10-1-87		2b HOUR 9:50 AM
3 SEX Female	4 RACE Black	5 DATE OF BIRTH MONTH DAY YEAR Dec. 5, 1937		6 AGE (IN YEARS LAST BIRTHDAY) 49 YRS
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D.C.	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD
10 CITY OR TOWN OF DEATH CLINTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None	12b KIND OF BUSINESS OR INDUSTRY
13a STATE Maryland		13b COUNTY PG	13c CITY OR TOWN Temple Hill	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST James Ray		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth Ellen Lee		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO 577 46 3633	17 INFORMANT ADDRESS Angela Curry-niece-5018 57th Ave	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>pulmonary embolus</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>metastatic breast cancer</u>		18b DECEASED'S OTHER CAUSE OF DEATH (TYPE AND PRINT)
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PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18b PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (1) this hospital attended the deceased from <u>fall 86</u> to <u>Oct 1</u> 19 <u>87</u> that (2) we last saw the deceased alive on <u>Sept 30</u> 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death)			
22b SIGNATURE <u>[Signature]</u> MD		22c DATE SIGNED <u>10/1/87</u>	
22d PHYSICIAN'S NAME (TYPE AND PRINT) <u>DR. NAIDAK MD</u>		22e ADDRESS <u>[Address]</u>	

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE Oct. 7, 1987	23c NAME OF CEMETERY OR CREMATORY Harmony Memorial Park	23d LOCATION CITY OR TOWN COUNTY Landover, Maryland
24 FUNERAL DIRECTOR NAME Stewart Funeral Home-4001 Benning Road, NE.		25a DATE REC'D BY REGISTRAR OCT 09 1987	25b REGISTRAR'S SIGNATURE <u>[Signature]</u>

DHMH 16 60M 7 B4
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the official of jurisdiction and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove card to registrar. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

068524 OCT 14 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) ADELE HENRIETTA ALMO		2a DATE OF DEATH MONTH DAY YEAR 10 8 87		2b HOUR 5 55 AM
3 SEX Female	4 RACE Caucasian	5 DATE OF BIRTH MONTH DAY YEAR 9-29-1921		6 AGE (IN YEARS LAST BIRTHDAY) 66 YRS
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash, DC	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PAINCO BOON BOS CO MD
10 CITY OR TOWN OF DEATH CLINTON	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SO. MARYLAND HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife.	12b KIND OF BUSINESS OR INDUSTRY Home
13a STATE Maryland 13b COUNTY Charles 13c CITY OR TOWN Waldorf 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e STREET ADDRESS / ZIP CODE Rt. 925N, Box 10/ 20601				
14 FATHER'S NAME FIRST MIDDLE LAST Edward J. Wheeler		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rena B. Craig		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO. 112-12-3169		17 INFORMANT ADDRESS Jerome J. Almo same as # 13
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Breast Cancer DUE TO, OR AS A CONSEQUENCE OF (b) Hepatic Metastasis 20 to Breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) Cancer				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 YEARS
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Seizure Disorder				
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE
22a I certify that (I) (this hospital) attended the deceased from 6/16 , 19 83 , to 10/8 , 19 87 that (I) (we) last saw the deceased alive on 10/7 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
22b SIGNATURE Harvey I. Katzen		DEGREE MD		22c DATE SIGNED 10/8/87
22d PHYSICIAN'S NAME (TYPE OR PRINT) HARVEY I. KATZEN		22e ADDRESS 8924 Woodman Rd Clinton MD		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 10-13-87	23c NAME OF CEMETERY OR CREMATORY St. Peters Cem.		23d LOCATION CITY OR TOWN COUNTY STATE Waldorf, Chas., Md.
24 FUNERAL DIRECTOR NAME Hunt Funeral Home		25 DATE REC'D. BY REGISTRAR 10/13/87		25 REGISTRAR'S SIGNATURE [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please return to Baltimore, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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OCT 13 1901

068988 OCT 20 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16 60M 7-84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

30207

REG. NO.

FOR
1- STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELIZABETH TAYMAN ANDERSON		2a DATE OF DEATH MONTH DAY YEAR 10 10 87		2b HOUR 4:35 PM	
3 SEX FEMALE	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR 3/22/1944		6 AGE (IN YEARS LAST BIRTHDAY) 43 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD	
10 CITY OR TOWN OF DEATH Riverdale	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5304 RIVERDALE RD - APT 705		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING YEARS) HOUSEWIFE		12b KIND OF BUSINESS OR INDUSTRY JOINT CONTAINER CO
13a STATE MD	13b COUNTY PR GEOR	13c CITY OR TOWN RIVERDALE	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST CHARLES AGLE TAYMAN		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST REBA SIEBERG			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO ---		17 INFORMANT ADDRESS RICHARD AGLE ANDERSON - RIVERDALE MD 20737	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMATOSIS DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) SMALL CELL CARCINOMA OF LUNG DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 MONTHS
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (1) this hospital attended the deceased from July 19 87 to Oct 10 19 87 and that (2) the deceased gave on Sept 20 19 87 and that (3) my opinion death occurred on the date and hour and from the causes stated above. (I have) (did not) view the body after death.					
22b SIGNATURE P. Schessler		DEGREE MD		22c DATE SIGNED 10/10/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) P. SCHESSLER MD		22e ADDRESS 7500 GREENWAY CTR DR GREENBELT MD 20770			
23a BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) BURIAL		23b DATE 10/13/87		23c NAME OF CEMETERY OR CREMATORY St Thomas Cem	
23d LOCATION (CITY OR TOWN) COUNTY STATE Green P.G. MD		24 FUNERAL DIRECTOR WALTER A. COLEMAN ADDRESS OFFICE: 11111 GREENWAY CTR DR MD 20770			
25 DATE REC'D BY REGISTRAR OCT 19 1987		26 REGISTRAR'S SIGNATURE John D. Anderson			

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160

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68836 OCT 16 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

FOR
1- STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Moude

E.

Arnold

2a DATE KNOWN OF DEATH
MONTH DAY YEAR
9-29 19 87

2b HOUR
M

3 SEX

Female

4 RACE

Black

5 DATE OF BIRTH

Jan. 6, 1901

6 AGE (IN YEARS)

86 YRS.

IF UNDER 1 YR

MONTHS DAYS

IF UNDER 24 HRS

HOURS MIN

7c DATE
PRONOUNCED
DEAD

MONTH DAY YEAR
9-29 19 87

7d HOUR
M

7a BIRTHPLACE
(STATE OR FOREIGN COUNTRY)

Md.

7b CITIZEN OF WHAT COUNTRY?

U.S.A.

8 MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

PRINCE GEORGES COUNTY MD

10 CITY OR TOWN OF DEATH

CLINTON

11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

SOUTHERN MARYLAND HOSPITAL

12a USUAL OCCUPATION (TYPE OF WORK)

Supervisor

12b KIND OF BUSINESS OR INDUSTRY

Salad Bar

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

Md.

13b COUNTY

P.G.

13c CITY OR TOWN

Oxon Hill

13d INSIDE CITY LIMITS?

YES ☒ NO ☐

13e STREET ADDRESS

704 Neptune Ave.

14 FATHER'S NAME

James

MIDDLE

A.

LAST

Harper

15 MOTHER'S MAIDEN NAME

Laura

MIDDLE

A.

LAST

Contee

16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)

No

16b SOCIAL SECURITY NO.

578-44-6450

17 INFORMANT

Alice Newman- Upper Marlboro, Md.

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.

Anteruptive Cardiovascular disease

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I

Arthritis

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED?

20 AUTOPSY?

YES ☐ NO ☒

21a EXTERNAL CAUSE WAS

UNDERLYING ☐ OR
CONTRIBUTING ☐ CAUSE OF DEATH

21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e PLACE OF INJURY (AT HOME
STREET, FACTORY, FARM, ETC.)

21f LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a I certify that I took charge of the remains described above, held an
death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

Autopsy ☐Inspection ☒Inquiry ☐

and in my opinion

ACTUAL SIGNATURE

Augusto P. Rodriguez

TITLE (SPECIFY)

M.D. Deputy

MEDICAL EXAMINER

DATE SIGNED

9-30-87

EXAMINER'S NAME (TYPE OR PRINT)

Augusto P. Rodriguez, M.D.

ADDRESS 5009 Rayburn Ct., Temple Hills, MD

23a BURIAL, CREMATION, REMOVAL (SPECIFY)

23b DATE

10/3/87

23c NAME OF CEMETERY OR CREMATORY

HARMONY MEM. PK.

23d LOCATION (CITY OR TOWN)

LANSOVER, P.G. MD.

COUNTY STATE

24 FUNERAL DIRECTOR

NAME

H.S. WASHINGTON & SONS

ADDRESS

4925 BURROUGHS AVE. N.E.

25a DATE REC'D. BY REGISTRAR

OCT 15 1987

25b REGISTRAR'S SIGNATURE

[Signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07-84
25M

BP

DHMH - 17
(VR A15 ME (5))

100-100-100-100

100-100-100-100

100-100-100-100

100-100-100-100

100-100-100-100

100-100-100-100

100-100-100-100

100-100-100-100

100-100-100-100

100-100-100-100

100-100-100-100

100-100-100-100

100-100-100-100

100-100-100-100

100-100-100-100

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

DECEASED NAME

LOUISE

FIRST

MIDDLE

LAST

R.

AXT

2a DATE OF DEATH

10 03 87

MONTH

DAY

YEAR

2b HOUR

4:50 P M

3 SEX

FEMALE

4 RACE

CAUCASIAN

5 DATE OF BIRTH

07 29 02

MONTH

DAY

YEAR

6 AGE (IN YEARS, LAST BIRTHDAY)

85

YRS

9 BALTIMORE CITY OR COUNTY OF DEATH

PRINCE GEORGE CO. MD

7a BIRTHPLACE (COUNTRY)

MARYLAND

7b CITIZEN OF WHAT COUNTRY?

U.S.A.

8 MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

10 CITY OR TOWN OF DEATH

RIVERDALE

11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

LELAND MEMORIAL HOSPITAL

12a USUAL OCCUPATION (GIVE USUAL TYPE OF WORKING LIFE)

HOUSEWIFE

12b KIND OF BUSINESS OR INDUSTRY

13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13b STATE

MARYLAND

13c COUNTY

MONTGOMERY

13d CITY OR TOWN

COLLEGE PARK

13e INSIDE CITY LIMITS?

YES ☐ NO ☐

13f STREET ADDRESS / ZIP CODE

P.O. BOX 353 20740

14 FATHER'S NAME

ROSS

MIDDLE

REILY

15 MOTHER'S MAIDEN NAME

MARGARET

O'RILLA

GUESSFORD

16a WAS DECEASED EVER IN U.S. ARMED FORCES?

YES, NO OR (UNKNOWN)

NO

(IF YES, GIVE WAR OR DATES)

16b SOCIAL SECURITY NO.

216-46-5993

17 INFORMANT

ADDRESS

RIDGELY W. AXT, JR./SON/SAME AS 13

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Cardiac arrest

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

minutes

912

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

(b) Acute myocardial infarction with regurgitation and aspiration

Hours

DUE TO, OR AS A CONSEQUENCE OF

(c) Pulmonary vascular disease

Days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.

Decubiti on back and left heel, Aspiration pneumonia

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY

YES ☐ NO ☒

20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER NOTIFY MEDICAL EXAMINER)

21b TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c HOW INJURY OCCURRED

ENTER NATURE OF INJURY IN ITEM 21c OR PART 2 (IF PART 2)

21d INJURY OCCURRED

DURING ☐ WHILE ☐AT WORK ☐ AT HOME ☐

21e PLACE OF INJURY

(AT HOME STREET FACTORY OFFICE FARM ETC.)

21f LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a I certify that (I) (the hospital) attended the deceased from

19 84

to

October 3

19 87

that (I) (we) last

saw the deceased alive on

Oct 3

19 87

and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

22b SIGNATURE

Byrl D. Johnson

DEGREE

MD

ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c DATE SIGNED

10/4/87

22d PHYSICIAN'S NAME (TYPE OR PRINT)

BYRL D. JOHNSON

22e ADDRESS

4404 QUEENSBURY ROAD RIVERDALE, MD 20737

23a BURIAL, CREMATION, REMOVAL (SPECIFY)

BURIAL

23b DATE

OCT 6, 1987

23c NAME OF CEMETERY OR CREMATORY

ROCK CREEK CEMETERY

23d LOCATION

WASHINGTON, D.C.

COUNTY

STATE

24 FUNERAL DIRECTOR

500 UNIVERSITY BLVD W SILVER SPRING, MD 20901

25a DATE REC'D BY REGISTRAR

OCT 07 1987

25b REGISTRAR'S SIGNATURE

Julia Davidson-Rodell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be delivered to the funeral director, who shall be responsible for its use as the burial-transit permit. Then please remove carbon copies from this certificate and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, it should be accompanied by a medical certificate.

107007 OCT 007



OCT 07 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO.

1- STATE
REGISTRAR

DECEASED NAME

FIRST

MIDDLE

LAST

THOMAS

P.

BACON

2a DATE KNOWN OF DEATH ESTIMATED 9-11-87
MONTH DAY YEAR

3 SEX

Male

4 RACE

White

5 DATE OF BIRTH

July 2, 1935

52 RS

6 AGE (IN YEARS)

52 RS

IF UNDER 1 YR

IF UNDER 24 HRS

7c DATE

10-14-87

PRONOUNCED DEAD

2b HOUR

5:40 PM

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b CITIZEN OF WHAT COUNTRY?

USA

8 MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Prince George's County

MD

10 CITY OR TOWN OF DEATH

Forestville

11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

7125 Donnell Place Apt. C-3

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

dependent

12b KIND OF BUSINESS OR INDUSTRY

13a STATE

Maryland

13b COUNTY

Pr George

13c CITY OR TOWN

Forestville

13d INSIDE CITY LIMITS?

YES ☐ NO ☐

13e STREET ADDRESS

7125 Donnell Place #103

14 FATHER'S NAME

Carl

MIDDLE

LAST

Bacon

15 MOTHER'S MAIDEN NAME

Esther

MIDDLE

LAST

Pearson

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)

No

16b SOCIAL SECURITY NO.

17 INFORMANT

ADDRESS H-C1 Box 82

Granville Pearson Front Royal, Va

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED?

20 AUTOPSY?

YES ☒ NO ☐

21a EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b TIME OF INJURY

HOUR A.M. MONTH DAY YEAR
P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART II OR PART 2)

21d INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)

21f LOCATION

CITY OR TOWN COUNTY STATE

22a I certify that I took charge of the remains described above, held on Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE

Margarita A. Korell

M.D.

TITLE (SPECIFY)

Assistant

MEDICAL EXAMINER

DATE SIGNED 10-15-87

EXAMINER'S NAME (TYPE OR PRINT)

Margarita A. Korell, M.D.

ADDRESS

111 Penn Street

23a BURIAL, CREMATION, REMOVAL

Cremation

23b DATE

200ct1987

23c NAME OF CEMETERY OR CREMATORY

Cedar Hill Crematory

23d LOCATION

Suitland PG

COUNTY

Md

24 FUNERAL DIRECTOR

NAME Robert E Wilhelm

ADDRESS

Funeral Home

Suitland

Md

25a DATE REC'D. BY REGISTRAR

OCT 26 1987

25b REGISTRAR'S SIGNATURE

[Signature]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

100001 100001

11



68825 OCT 16 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

30211

1. DECEASED NAME (TYPE OR PRINT) ARTHUR DeWitt BAKER, SR.			2a. DATE OF DEATH MONTH DAY YEAR 10 9 87		2b. HOUR 11 35 PM			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR April 7 1905		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD		
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Optician -Self Emp.		12b. KIND OF BUSINESS OR INDUSTRY Optician	
13a. STATE Maryland				13b. COUNTY Prince George		13c. CITY OR TOWN Clinton		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE 12800 Gallahan Rd. 20735				
14. FATHER'S NAME FIRST MIDDLE LAST George Arthur Baker				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva Tarbox				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 150-09-6375A		17. INFORMANT ADDRESS Marguerite S. Baker 12800 Gallahan Rd. Clinton, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CEREBRO-VASCULAR ACCIDENT</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>PERIPHERAL VASCULAR DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>DIABETES MELLITUS</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u> <u>25 YEARS</u> <u>14 YEARS</u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 3b, PART 3, OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>JAN 30</u> 19 <u>80</u> to <u>OCT 9</u> 19 <u>87</u> that (I) last saw the deceased alive on <u>OCT 9</u> 19 <u>87</u> and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was <u>did not</u> view the body after death.								
22b. SIGNATURE <i>J. Sanford Young</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/10/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Sanford Young, M.D.				22e. ADDRESS 11701 Livingston Rd., Ft. Washington, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/12/87		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland		
24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home, Oxon Hill, Md 20745				25a. DATE REC'D BY REGISTRAR OCT 15 1987				

the medical examiner must be notified at once.

98032 OCT 18 91

OCT 18 1991

069022 OCT 20 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

30212

FOR
STATE
REGISTRAR

1- DECEASED NAME
(TYPE OR PRINT)

John

FIRST

MIDDLE

LAST

Barber

2a. DATE KNOWN OF DEATH
ESTIMATED
MONTH DAY YEAR
10-9 1987
2b. HOUR
M

3 SEX

Male

4 RACE

Black

5 DATE OF BIRTH

July 9, 1936

6 AGE (IN YEARS)

51 YRS.

IF UNDER 1 YR

MONTHS DAYS HOURS MIN.

IF UNDER 24 HRS

2c. DATE PRONOUNCED DEAD

10-9 1987

MONTH DAY YEAR

2d. HOUR

7:30 AM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Washington, D.C.

7b. CITIZEN OF WHAT COUNTRY?

USA

8 MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

9 BALTIMORE CITY OR COUNTY OF DEATH

Prince George's

MD

10 CITY OR TOWN OF DEATH

Cheverly

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

Prince Georges General Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Crew Chief

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

P.G.

13c. CITY OR TOWN

Capitol Hgts

13d. INSIDE CITY LIMITS?

YES NO

13e. STREET ADDRESS

104 Daimler Avenue

20743

14 FATHER'S NAME

Joseph

MIDDLE

LAST

Barber

15 MOTHER'S MAIDEN NAME

Mary

MIDDLE

LAST

Milburn

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)

no

16b. SOCIAL SECURITY NO.

579 52 4738

17 INFORMANT

Gloria Barber-wife-104 Daimler Ave.

ADDRESS

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY

IMMEDIATE CAUSE

Capitol Heights, Maryland
Arterio-plateau cardiovascular disease

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

(b) DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20 AUTOPSY?

YES NO

21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21e. PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE

Augusto P. Rodriguez

TITLE (SPECIFY)

Deputy

MEDICAL EXAMINER

DATE SIGNED

10-9-87

EXAMINER'S NAME (TYPE OR PRINT)

Augusto P. Rodriguez

ADDRESS

5009 Rayburn Ct. Cap Spr. Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

Oct. 14, 1987

23c. NAME OF CEMETERY OR CREMATORY

Harmony Memorial Park

23d. LOCATION (CITY OR TOWN)

Landover, Md.

COUNTY

STATE

24 FUNERAL DIRECTOR NAME

Stewart

ADDRESS

Stewart

25a. DATE REC'D BY REGISTRAR

NOV 16 1987

25b. REGISTRAR'S SIGNATURE

John Stewart

DHMH - 17
(VR A15 ME 11)

BP

07-84
25M

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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069637 0012687

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

30213

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) JOSEPH G. BARTH			7a DATE OF DEATH MONTH DAY YEAR 10-17-87			7b HOUR 11:28AM			
3 SEX Male		4 RACE Cauc.		5 DATE OF BIRTH MONTH DAY YEAR July 14, 1947		6 AGE (IN YEARS LAST BIRTHDAY) 40		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (CITY OR TOWN, STATE OR FOREIGN COUNTRY) Was., D.C.		7b CITIZEN OF WHAT COUNTRY? US.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD			
10 CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGE'S HOSPITAL CENTER		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self-Employed		12b KIND OF BUSINESS OR INDUSTRY Upholsterer			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a STATE Md.		13b COUNTY Pr.Geo.		13c CITY OR TOWN N.Carrollton		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 6501 Lamont Dr. 20784	
14 FATHER'S NAME FIRST MIDDLE LAST Joseph A. Barth				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Norma B. Gordon					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 214-48-7388		17 INFORMANT Joseph A. Barth		ADDRESS 7437 Parkwood St. Hyattsville, Md. 20784			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>BILATERAL BRONCHIAL PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } b) <u>SEPSIS</u> DUE TO, OR AS A CONSEQUENCE OF c) <u>CHRONIC DISEASE</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NO: WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____ that (I) (we) last saw the deceased on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) and others signing the below after death.									
22b SIGNATURE <i>[Signature]</i>				DEGREE M.D.				22c DATE SIGNED 10/17/1987	
22d PHYSICIAN'S NAME (TYPE OR PRINT) IMAN MIKHAIL, M.D.				22e ADDRESS					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10/21/87		23c NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		23d LOCATION CITY OR TOWN COUNTY STATE Brentwood, Maryland			
24 FUNERAL DIRECTOR NAME Rendon/Hale Lanham Fun'l Home 9013 Annapolis Rd. Lanham, Md. 20706									

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This certificate is valid for 24 hours after death.

with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner should be notified at once.

BP

080331 OCT 20 11

RECEIVED

RECEIVED

OCT 22 1961

30214

070420 NOV-287

STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

FOR
 STATE
 REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)				2a DATE OF DEATH		2b HOUR	
FIRST MIDDLE LAST CECILIA T. BECKER				MONTH DAY YEAR 10 28 87		6 ⁰⁰ PM	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE	
FEMALE		WHITE		MONTH DAY YEAR 4 11 1897		(IN YEARS LAST BIRTHDAY) 90 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
MARYLAND		U.S.A.				Prince Georges County MD	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Fort Washington		Fort Washington Rehab. Center		BEAUTICIAN		SELF EMP.	
13a USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?	
MARYLAND				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
JOSEPH HELFRICK				UNKNOWN			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO		17 INFORMANT ADDRESS			
NO		217-32-9778		HENRY J. BECKER 509 HOLLY RD. 20744			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART 1 DEATH WAS CAUSED BY							
IMMEDIATE CAUSE (a) <u>Cardio-Respiratory Arrest</u>							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							
(b) _____							
DUE TO, OR AS A CONSEQUENCE OF							
(c) _____							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18B PART 1 OR PART 2)			
21d INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>1-18</u> 19 <u>85</u> to <u>10-28</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>10-8</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE				DEGREE		22c DATE SIGNED	
<u>William Kent Furit</u>				MD		10 29 87	
22d PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS			
William Kent Furit				11701 Livingston Rd. #101 20744			
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE	
BURIAL		10/31/87		HOLY CROSS CEM.		BROOKLYN PK. A.A. MARYLAND	
24 FUNERAL DIRECTOR NAME ADDRESS				25a DATE OF DEATH		25b REGISTRAR'S SIGNATURE	
HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.				20744		<u>Julia D. ...</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

 IMPORTANT: If item 21 is marked as item 18, there is any injury, or other traumatic event, the medical examiner must be notified at once.

BP

 DHMH - 16 60M 7-84
 (VRA 15, 4)

10-2-1941

10-2-1941

10-2-1941

10-2-1941

10-2-1941

10-2-1941

10-2-1941

10-2-1941

10-2-1941

10-2-1941

OCT 30 1941

071137 NOV-30

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3021

REG. NO.

FOR
STATE
REGISTRAR

1- DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE KNOWN OF DEATH	2b DATE ESTI- MATED	MONTH	DAY	YEAR	2c HOUR
Martin Wayne Bell								10	31	1987	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS)	IF UNDER 1 YR	IF UNDER 24 HRS	7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED	NEVER MARRIED	XX	2d DATE PRONOUNCED DEAD
male	white	April 10, 1987	6			Maryland	USA				10-31-1987
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			9 BALTIMORE CITY OR COUNTY OF DEATH			12a USUAL OCCUPATION		
Laurel			Greater Laurel Beltsville Hospital			Prince George's County MD			none		
13a STATE			13b CITY OR TOWN			13d INSIDE CITY LIMITS?			13e STREET ADDRESS		
Maryland			Laurel			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			7302 Madison Avenue 20707		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			16a WAS DECEASED EVER IN U.S. ARMED FORCES?			16b SOCIAL SECURITY NO.		
unknown			Melissa Bell			no			214 15 6583		
17 INFORMANT			ADDRESS			18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
John Bell same as above						PART I DEATH WAS CAUSED BY:					

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
9138 IMMEDIATE CAUSE (a) Strangulation			
DUE TO, OR AS A CONSEQUENCE OF			
(b)			
DUE TO, OR AS A CONSEQUENCE OF			
(c)			

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 10-31-87		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
				Balloon cord wrapped around neck	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f LOCATION CITY OR TOWN, COUNTY, STATE 9302 Madison Street, Laurel, Prince George's	

22a I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/>		County, Maryland	
death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		TITLE (SPECIFY)	
Ann M. Dixon, M.D.		Deputy Chief	
EXAMINER'S NAME (TYPE OR PRINT)		DATE SIGNED 11-1-87	
ADDRESS 111 Penn Street, Baltimore, MD 21201			

23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION CITY OR TOWN, COUNTY, STATE
Burial	Nov. 2, 1987	Fort Lincoln Cemetery	Brentwood, Md
24 FUNERAL DIRECTOR		25a DATE REC'D BY REGISTRAR	
Donaldson Funeral Home, Laurel, Md		NOV 06 1987	
25b REGISTRAR'S SIGNATURE			
		Julia Frazier-Rodden	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 1 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

071157 101-017

100% COTTON FIBER

UNION MILITARY

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NOV 08 1961
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068180 OCT

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSPORT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

30216

REG NO

1 DECEASED NAME (TYPE OR PRINT)			2a DATE KNOWN OF DEATH			2b DATE OF ESTI MATED			2c DATE PRONOUNCED DEAD			2d DATE KNOWN OF DEATH			2e DATE OF ESTI MATED			2f DATE PRONOUNCED DEAD					
BRIAN Thomas BEST			10 7 19 87			10 7 19 87			10 7 19 87			10 7 19 87			10 7 19 87			10 7 19 87					
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (IN YEARS)			7a BIRTHPLACE			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED			9 BALTIMORE CITY OR COUNTY OF DEATH		
Male			Cauc			Apr. 18, 1961			26 YRS			Wash., D.C.			U.S.A.			NEVER MARRIED			Prince George's County		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a USUAL OCCUPATION			12b KIND OF BUSINESS OR INDUSTRY			13a STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?		
Cheverly			Prince George's General Hosp.			Chef			Food Prep.			Va			Fairfax			Fairfax			YES		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			16a WAS DECEASED EVER IN U.S. ARMED FORCES?			16b SOCIAL SECURITY NO.			17 INFORMANT			18 CAUSE OF DEATH			19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		
David J. Best			Norma Johnson			No			224-02-6973			David J. Best, 9426 Winterberry Ln			907								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?			21a EXTERNAL CAUSE WAS			21b TIME OF INJURY			21c HOW INJURY OCCURRED			21d INJURY OCCURRED			21e PLACE OF INJURY		
						YES			UNDERLYING			11:30M. 10-6- 19 87			Subject struck by lightning.			WHILE AT WORK			parking lot		
22a I certify that I took charge of the remains described above, held an			Autopsy			Inspection			Inquiry			and in my opinion			22b I certify that I took charge of the remains described above, held an			Autopsy			Inspection		
death resulted from			Natural causes			Accident			Suicide			Homicide			Undetermined manner			22b I certify that I took charge of the remains described above, held an			Autopsy		
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED			23a BURIAL, CREMATION, REMOVAL			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION			23e DATE REC'D. BY REGISTRAR		
Ann M. Dixon, M.D.			Deputy Chief			10-7-87			Burial			Oct. 10, 1987			Columbia Gardens			Arlington, Va.			OCT - 8 1987		
EXAMINER'S NAME			ADDRESS			24 FUNERAL DIRECTOR			25a DATE REC'D. BY REGISTRAR			25b REGISTRAR'S SIGNATURE			26a DATE REC'D. BY REGISTRAR			26b REGISTRAR'S SIGNATURE			26c DATE REC'D. BY REGISTRAR		
Ann M. Dixon, M.D.			111 Penn St., Balto., MD 21201			Murphy Funeral Home			OCT - 8 1987			Julia D. Dixon-Randall			OCT - 8 1987			Julia D. Dixon-Randall			OCT - 8 1987		

DHMH 17
(VR A15 ME 15)

20% COTTON: EMBE



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1000

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068176 OCT-987

FOR STATE REGISTRAR
 10-23-87 med. exam.
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

30217

1 DECEASED NAME (TYPE OR PRINT) Clint			2a DATE KNOWN OF DEATH ESTIMATED 10-2-1987			7b HOUR 2:04 A.M.			
3 SEX Male		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR 01 9 57		6 AGE (IN YEARS) (LAST BIRTHDAY) 30 YRS.		7c DATE PRONOUNCED DEAD MONTH DAY YEAR 10-2-1987	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD			
10 CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN WHICH FACILITY, GIVE STREET ADDRESS) Prince George's General Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b KIND OF BUSINESS OR INDUSTRY Government	
13a STATE Maryland			13b COUNTY P. Georges		13c CITY OR TOWN Lanham		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e STREET ADDRESS 2916 Brightseat Rd #101			14 FATHER'S NAME FIRST MIDDLE LAST Robert C. Black			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Demetrice Ashton			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. 7/75-2/77		17 INFORMANT Andrea Black		2916 ^{DR} Brightseat Rd. Lanham Md. 20706			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Narcotic and alcohol intoxication</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?					20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 10-2 1987		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Subject took drugs and alcohol				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.) House		21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>									
ACTUAL SIGNATURE <i>Charles P. Kokes</i>			M.D. Assistant			MEDICAL EXAMINER		DATE SIGNED 10-2-87	
EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D.			ADDRESS 111 Penn Street, Balto., MD 21201						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 10-8-87		23c NAME OF CEMETERY OR CREMATORY Harmony Memorial Pk		23d LOCATION CITY OR TOWN COUNTY STATE Landover P.G. Md.		
24 FUNERAL DIRECTOR NAME J.B. Jenkins			ADDRESS 7474 Landover Road Landover, Md. 20785			25a DATE REC'D BY REGISTRAR OCT - 8 1987		25b REGISTRAR'S SIGNATURE <i>Julia Tidwell-Randall</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07 '84
25MDHMH - 17
(VR A15 ME (5))

18e-130 051000

20% COTTON BLEND

WINTER



068677 OCT 15 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) AKA(Gellispie) GELESPIE C. BLACKWELL				2a DATE OF DEATH MONTH DAY YEAR 09 30 87		2b HOUR 2:25A M	
3 SEX MALE		4 RACE BLACK		5 DATE OF BIRTH MONTH DAY YEAR 11 21 21		6 AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN 65 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C. United States		7b CITIZEN OF WHAT COUNTRY? C. United States		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD	
10 CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GLADYS NOON SPELLMAN NURS. CARE CEN		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Custodian		12b KIND OF BUSINESS OR INDUSTRY Private	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD.		13b COUNTY P.G.		13c CITY OR TOWN Forest Hghts.		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Unknown		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Blackwell		13e STREET ADDRESS / ZIP CODE 5702 Woodland Drive 20747			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO 579-12-3090		17 INFORMANT ADDRESS Debra Snead Daughter Same as 13e			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Septicemia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Infect decubitus ulcers.</u> DUE TO, OR AS A CONSEQUENCE OF } (c) <u>Paraplegia</u>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Severe Peripheral Vascular Disease</u>							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>12.25</u> 19 <u>87</u> to <u>9.30</u> 19 <u>85</u> that (I) (we) last saw the deceased alive on <u>9.21</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (that) did not view the body after death.							
22b SIGNATURE <u>[Signature]</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <u>9.30.87</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) I SURY		22e ADDRESS 6005 Landover Rd #6 Cheverly Md 20885					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 06Oct.87		23c NAME OF CEMETERY OR CREMATORY Cheltenham Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Cheltenham Maryland	
24 FUNERAL DIRECTOR NAME Frazier's Funeral Home				ADDRESS 389 R.I. Ave N.W.		25a DATE REC'D BY REGISTRAR OCT 14 1987	
				25b REGISTRAR'S SIGNATURE <u>[Signature]</u>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7-84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

1. The first part of the document is a list of names and addresses. The names are written in a cursive script, and the addresses are written in a more formal, printed style. The list is organized into columns, with names in the first column and addresses in the second column.

2. The second part of the document is a list of names and addresses, similar to the first part. The names are written in a cursive script, and the addresses are written in a more formal, printed style. The list is organized into columns, with names in the first column and addresses in the second column.

3. The third part of the document is a list of names and addresses, similar to the first two parts. The names are written in a cursive script, and the addresses are written in a more formal, printed style. The list is organized into columns, with names in the first column and addresses in the second column.

4. The fourth part of the document is a list of names and addresses, similar to the first three parts. The names are written in a cursive script, and the addresses are written in a more formal, printed style. The list is organized into columns, with names in the first column and addresses in the second column.

5. The fifth part of the document is a list of names and addresses, similar to the first four parts. The names are written in a cursive script, and the addresses are written in a more formal, printed style. The list is organized into columns, with names in the first column and addresses in the second column.

6. The sixth part of the document is a list of names and addresses, similar to the first five parts. The names are written in a cursive script, and the addresses are written in a more formal, printed style. The list is organized into columns, with names in the first column and addresses in the second column.

7. The seventh part of the document is a list of names and addresses, similar to the first six parts. The names are written in a cursive script, and the addresses are written in a more formal, printed style. The list is organized into columns, with names in the first column and addresses in the second column.

8. The eighth part of the document is a list of names and addresses, similar to the first seven parts. The names are written in a cursive script, and the addresses are written in a more formal, printed style. The list is organized into columns, with names in the first column and addresses in the second column.

9. The ninth part of the document is a list of names and addresses, similar to the first eight parts. The names are written in a cursive script, and the addresses are written in a more formal, printed style. The list is organized into columns, with names in the first column and addresses in the second column.

10. The tenth part of the document is a list of names and addresses, similar to the first nine parts. The names are written in a cursive script, and the addresses are written in a more formal, printed style. The list is organized into columns, with names in the first column and addresses in the second column.

068351 OCT 13 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

30219

REG NO

1 DECEASED NAME (TYPE OR PRINT) Ellen (no middle name) BLAHA			2a DATE OF DEATH MONTH DAY YEAR October 4, 1987			2b HOUR 8:05 PM				
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR June 3, 1924		6 AGE (IN YEARS LAST BIRTHDAY) 63 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 24 HRS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Chzechoslovakia		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD				
10 CITY OR TOWN OF DEATH Lanham		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) A.M.I. Doctors' Hospital			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY Own Home			
13a STATE MD			13b COUNTY Pr. Geos.		13c CITY OR TOWN Lanham		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 6716 Lamont Drive/20706	
14 FATHER'S NAME FIRST MIDDLE LAST Vaclav -- Bochynek			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lea -- Plockova			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No ---			16b SOCIAL SECURITY NO. 214-82-7488	
17 INFORMANT ADDRESS Milan Blaha, Same address as #13.			18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Lactic acidosis, ASCVD</u>										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22 I certify that (1) this hospital attended the deceased from <u>10/4</u> 19 <u>87</u> to <u>10/4</u> 19 <u>87</u> that (1) we last saw the deceased alive on <u>10/4</u> 19 <u>87</u> and that in my <u>own</u> opinion death occurred on the date and hour and from the causes stated above (1) we did not view the body after death.										
22b SIGNATURE <u>D. Granite</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED <u>10/5/87</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>D. Granite, MD</u>			22e ADDRESS <u>115 Centerway Greenbelt, Md.</u>							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b DATE 10/6/87		23c NAME OF CEMETERY OR CREMATORY Mt. Comfort Crematory		23d LOCATION CITY OR TOWN COUNTY STATE Alexandria, VA			
24 FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc.			25a DATE RECEIVED BY REGISTRAR OCT 09 1987			25b REGISTRAR'S SIGNATURE <u>[Signature]</u>				
5130 Wisconsin Ave, NW, Washington, D.C. 20016										

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

068321 OCT 13 1976

69592 OCT 23 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Ann Blythe			2a DATE OF DEATH MONTH DAY YEAR October 16, 1987		2b HOUR A 9:30 M
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR October 10, 1914		6 AGE (IN YEARS LAST BIRTHDAY) 73 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b CITIZEN OF WHAT COUNTRY? United States	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD	
10 CITY OR TOWN OF DEATH Seabrook	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9615 Woodberry Street		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b KIND OF BUSINESS OR INDUSTRY Trucking
13a STATE Maryland	13b COUNTY Prince George's	13c CITY OR TOWN Seabrook	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST Charles Kriznowski		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Barbara (Unavailable)			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO 190-01-8577		17 INFORMANT ADDRESS George W. Blythe, Same as 13	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last } (b) <u>Colon cancer with liver metastases</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>8 years</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> (OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER))		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY, ITEM 18B PART I, OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>9/17</u> 19 <u>87</u> to <u>10/16</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>9/17</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <u>Aron Primack</u>		DEGREE <u>MD</u>		22c DATE SIGNED 10-16-87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Aron Primack, M. D.		22e ADDRESS 106 Irving Street, NW, 421 Washington, DC 20010			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE 10-17-87	23c NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d LOCATION (CITY OR TOWN COUNTY STATE) Alexandria, Virginia
24 FUNERAL DIRECTOR NAME Richard Rapp, Inc.			25a DATE REC'D. BY REGISTRAR OCT 22 1987		
P. O. Box 43352, Washington, DC 20010			25b REGISTRAR'S SIGNATURE <u>Lelia Davidson-Randall</u>		

20% CQ10CM HIBED

CHIEF OF POLICE



X-100

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

068454 OCT 14 1987

DECEASED NAME (TYPE OR PRINT) Ethelyn M. Boccheciamp			7a DATE OF DEATH MONTH DAY YEAR October 8, 1987		7b HOUR P. 8:22 M.
3 SEX Female	4 RACE Caucasian	5 DATE OF BIRTH MONTH DAY YEAR May 30, 1902		6 AGE (IN YEARS, LAST BIRTHDAY) 85 YRS.	8 UNDER 1 YEAR 9 UNDER 1 YEAR 10 UNDER 1 YEAR 11 UNDER 1 YEAR
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Panama	7b CITIZEN OF WHAT COUNTRY? U S A	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.	
10 CITY OR TOWN OF DEATH Hyattsville	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hyattsville Manor		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b KIND OF BUSINESS OR INDUSTRY Own home	
13a STATE Maryland		13b COUNTY Mont.	13c CITY OR TOWN Takoma Park	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 906 Browning Ave, 20912
14 FATHER'S NAME FIRST MIDDLE LAST David Pretto		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Oliva Satiou		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES No	
16b SOCIAL SECURITY NO. 063-05-8802		17 INFORMANT (20903) ADDRESS 10804 Blossom Lane, Md			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) <u>Cerebrovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs 6 hrs					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 10/8/87 to 10/8/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body (after death).					
22b SIGNATURE Myron L. Lenkin		DEGREE MD		22c DATE SIGNED 10/9/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Myron L. Lenkin		22e ADDRESS 2309 Shorefield Rd., Wheaton, Md.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10/11/87	23c NAME OF CEMETERY OR CREMATORY George Washington		23d LOCATION CITY OR TOWN COUNTY STATE Adelphi, P.G.Co., Md.
24 FUNERAL DIRECTOR NAME Takoma Funeral Home-Washington, D.C.		25a DATE REC'D BY REGISTRAR OCT 13 1987		25b REGISTRAR'S SIGNATURE Julia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

28421 OCT 14 87



OCT 13 1987

068882 OCT 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

30222

1 DECEASED NAME (TYPE OR PRINT)		FIRST Steven		MIDDLE James		LAST Bosworth II		2a DATE KNOWN OF ESTI- DEATH MATED		MONTH 10		YEAR 1987		2b HOUR 8		2c DATE PRONOUNCED DEAD		MONTH 10		YEAR 1987		2d HOUR 7	
3 SEX M		4 RACE W		5 DATE OF BIRTH MONTH Feb. 24		6 AGE (IN YEARS) (LAST BIRTHDAY) 22		IF UNDER 1 YR MONTHS DATE		IF UNDER 24 HRS HOURS MIN.		7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges		MD			
10 CITY OR TOWN OF DEATH Bowie		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 16310 Pewter Lane		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Fire Fighter		12b KIND OF BUSINESS OR INDUSTRY County Gov't		13a STATE MD		13b COUNTY Prince Georges		13c CITY OR TOWN Bowie		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 16310 Pewter Lane		14 FATHER'S NAME FIRST James		MIDDLE Steven		LAST Bosworth	
15 MOTHER'S MAIDEN NAME FIRST JoAnn		MIDDLE E.		LAST Pierpont		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b SOCIAL SECURITY NO. 215-72-7436		17 INFORMANT Same as # 13. Andrea Ellen Bosworth,		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Gunshot wound of head</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>		19a DATE OF OPERATION <u>None</u>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9:45 P.M. 10 19 87		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <u>Shot self</u>		21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY FARM ETC.) <u>Home</u>		21f LOCATION STREET <u>Pewter Lane</u>		CITY OR TOWN <u>Bowie</u>		COUNTY <u>Prince Georges</u>		STATE <u>MD</u>	
22a I certify that I took charge of the remains described above, held an death resulted from <u>Natural causes</u> <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		ACTUAL SIGNATURE <u>John S. Rogers</u>		TITLE (SPECIFY) M.D. <u>Dep.</u>		MEDICAL EXAMINER		DATE SIGNED <u>Oct. 11 1987</u>		EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.		ADDRESS 1919 Seminary Rd. Silver Spring, MD									
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Oct. 14, 1987		23c NAME OF CEMETERY OR CREMATORY Miranda Cemetery		23d LOCATION CITY OR TOWN Huntingtown, Calvert, Maryland		24 FUNERAL DIRECTOR NAME Beall Funeral Home		16000 Annapolis Rd. Bowie, Maryland		25a DATE REC'D BY REGISTRAR OCT 16 1987		25b REGISTRAR'S SIGNATURE <u>Julia S. ...</u>									

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE NO. 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORMS 1-4. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGE 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS OF DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07-84
25M

BP

DHMH 17
(VR A15 ME (1))

Handwritten notes and signatures at the top of the page, including a large signature that appears to read "John D. ...".

Main body of handwritten text, including a circular stamp or seal in the center. The text is mostly illegible due to fading and bleed-through.

Handwritten text at the bottom of the page, including a signature and some printed text that is partially visible.

068900 OCT 19 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

30222

1 DECEASED NAME (TYPE OR PRINT) MARION FRANCES BOWIE			2a DATE OF DEATH MONTH DAY YEAR 10 12 87			2b HOUR 8 50 AM				
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR 08 28 19		6 AGE (IN YEARS LAST BIRTHDAY) 68 YRS		IF UNDER 1 YEAR MONTH DAY HOURS MIN		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD				
10 CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NURSING CARE FACILITY (SPELLMAN)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b KIND OF BUSINESS OR INDUSTRY OWN HOME		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD.			13b COUNTY P.G.		13c CITY OR TOWN CHEVERLY		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE GLADYS SPELLMAN NUR.HOME 20785	

14 FATHER'S NAME FIRST MIDDLE LAST IRVIN BOWIE		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET GOODING	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b SOCIAL SECURITY NO 579-22-6741	
17 INFORMANT (SON)		5516 BERKLEY MANOR LANE LEO E. GRINDER CHURCHTON, MD. 20733	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Conjunctive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>chronic obstructive pulmonary disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>2 days</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a DATE OF OPERATION N/A		19b CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED N/A		21d NATURE OF INJURY IN ITEM 18, PART 1 (FOR PART 2)	
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21d INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE	
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22a I certify that (1) this hospital attended the deceased from 10/12/87 to 10/12/87, that (we) last saw the deceased alive on 10/12/87 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) not view the body after death.		22b SIGNATURE Don H. Yablonsky, MD		22c DATE SIGNED 10/12/87	
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22d PHYSICIAN'S NAME (TYPE OR PRINT) Don H. Yablonsky, MD		22e ADDRESS 10300 Greenbelt Rd., Seatons, Md.		22f ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
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23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE 10-15-87		23c NAME OF CEMETERY OR CREMATORY OLD DURHAM CH. CEM.		23d LOCATION IRONSIDES CHARLES MARYLAND	
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24 FUNERAL DIRECTOR NAME AREHART FUNERAL HOME, INC. LA PLATA, MD.		25 DATE RECEIVED BY FUNERAL DIRECTOR OCT 16 1987		26 REGISTRAR'S SIGNATURE Julia D. Robinson	
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27 DATE RECEIVED BY REGISTRAR OCT 16 1987		28 REGISTRAR'S SIGNATURE Julia D. Robinson	
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove all other papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 2 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP

DHMH 16 60M 7/B4
(VRA 15, 4)

24
070907 NOV 5 37STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

30222

REG NO

1- STATE REGISTRAR										2a DATE KNOWN OF DEATH EST. MATED										2b HOUR									
DECEASED NAME FIRST MIDDLE LAST										DATE KNOWN OF DEATH EST. MATED										HOUR									
LEONA MAE BOYER										0-8-27 19 57										440									
3 SEX 4 RACE 5 DATE OF BIRTH 6 AGE 7a BIRTHPLACE 7b CITIZEN OF WHAT COUNTRY?										8 MARRIED NEVER MARRIED WIDOWED DIVORCED										9 BALTIMORE CITY OR COUNTY OF DEATH									
Female Cau. 01-23-1907 80																				Prince George's									
10 CITY OR TOWN OF DEATH 11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION										12a USUAL OCCUPATION										12b KIND OF BUSINESS OR INDUSTRY									
Riverdale Leland Memorial Hospital										Housewife										Own Home									
13a STATE 13b CITY OR TOWN 13c STREET ADDRESS										14 FATHER'S NAME										15 MOTHER'S MAIDEN NAME									
Maryland Prince Geo. Hyattsville										Henry Newby Nettie Moore																			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? 16b SOCIAL SECURITY NO										17 INFORMANT ADDRESS																			
No 215-46-2253										Herman F. Boyer, Same as Line #13																			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Dis.																													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) Chronic Myocardial Dis.																													
(c)																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																													
19a DATE OF OPERATION										19b CONDITION FOR WHICH OPERATION WAS PERFORMED?										20 AUTOPSY?									
None																				YES NO									
21a EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH										21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR										21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
										P.M. 19																			
21d INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK										21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)										21f LOCATION STREET CITY OR TOWN COUNTY STATE									
22a I certify that I took charge of the remains described above, held on Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner																													
ACTUAL SIGNATURE										TITLE (SPECIFY)										DATE SIGNED									
EXAMINER'S NAME (TYPE OR PRINT)										M.D. Dap										0-8-27-1987									
ADDRESS																													
23a BURIAL, CREMATION, REMOVAL (SPECIFY)										23b DATE										23c NAME OF CEMETERY OR CREMATORY									
Burial										10-29-87										George Washington Cem. Adelphi, P.G., Maryland									
23d LOCATION CITY OR TOWN COUNTY STATE										24a DATE REC'D. BY REGISTRAR										24b REGISTRAR'S SIGNATURE									
FRANCIS GASCH'S SONS FUNERAL HOME, P.A.										NOV 4 1987										Julia Davidson-Randall									
4739 Baltimore Ave., Hyattsville, Maryland																													

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07-84
25A

BP

DHMH - 17
IVR A15 ME 15

705-NDI 705070

069692 OCT 26 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

30225

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <u>Carlyne Breckenridge</u>			2a DATE OF DEATH MONTH DAY YEAR <u>10-7-87</u>			2b HOUR <u>3:16 PM</u>					
3 SEX <u>FEMALE</u>		4 RACE <u>BLACK</u>		5 DATE OF BIRTH MONTH DAY YEAR <u>NOV. 25 1917</u>		6 AGE (IN YEARS LAST BIRTHDAY) <u>69</u>					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MARYLAND</u>		7b CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <u>Prince George</u> MD					
10 CITY OR TOWN OF DEATH <u>Hyattsville</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Meadow Manor Nursing Home</u>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>LAUNDRY</u>		12b KIND OF BUSINESS OR INDUSTRY <u>CLEANERS</u>			
13a STATE <u>MARYLAND</u>			13b COUNTY <u>P.G.</u>		13c CITY OR TOWN <u>CAP. HGTS</u>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <u>4811 FABLE ST.</u>		
14 FATHER'S NAME FIRST MIDDLE LAST <u>UNKNOWN</u>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>UNKNOWN</u>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>577-30-8646</u>			17 INFORMANT ADDRESS <u>WALTER L. BRECKENRIDGE 4811 FABLE ST.</u>					
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE 1a. <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF b. <u>Multiple Myeloma</u> DUE TO, OR AS A CONSEQUENCE OF c. <u>Anemia</u> PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a. <u>Organic Brain Syndrome</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that I (this hospital) attended the deceased from <u>2-27</u> 19 <u>87</u> to <u>10-7</u> 19 <u>87</u> that I (we) last saw the deceased alive on <u>10-7-</u> 19 <u>87</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did (did not) view the body after death.											
22b SIGNATURE <u>R. Arnold</u>			DEGREE <u>M.D.</u>			22c DATE SIGNED <u>10/7/87</u>					
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>Rakesh Arora</u>			22e ADDRESS <u>Bowie, Md. 20715</u> <u>14300 Gallant Fox Lane #222</u>								
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>			23b DATE <u>OCT. 14, 1987</u>		23c NAME OF CEMETERY OR CREMATORY <u>CHELTENHAM CEM.</u>		23d LOCATION CITY OR TOWN COUNTY STATE <u>CHELTENHAM MD.</u>				
24 FUNERAL DIRECTOR NAME ADDRESS <u>HUNT FUNERAL HOME 2801 7TH ST. N.E. D.C.</u>						25a DATE REC'D. BY REGISTRAR <u>OCT 23 1987</u>		25b REGISTRAR'S SIGNATURE <u>James Harrison-Randall</u>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

068521 OCT 14 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

30220

1. DECEASED NAME (TYPE OR PRINT) Doris Anne Bretscher			2a. DATE OF DEATH MONTH DAY YEAR Oct. 6 1987			2b. HOUR 4:28 P M		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Aug. 30 1932		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.		
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9039 Contee Road #301		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. UNIV. or BUS. or IND. or COLLEGE Univ. of Md. College		
13a. STATE Md.		13b. COUNTY P.G.		13c. CITY OR TOWN Laurel		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST George Kraemer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian (Unkown)		13e. STREET ADDRESS / ZIP CODE 9039 Contee Road #301 20708				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) n/a		16b. SOCIAL SECURITY NO. n/a		17. INFORMANT ADDRESS William J. Bretscher same as 13e				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic cancer of breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>8 years</u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NO: WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (his hospital) attended the deceased from <u>6/17, 1987</u> to <u>10/6, 1987</u> that (I) (we) last saw the deceased alive on <u>10/6, 1987</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bruce A. Silver MD				22e. ADDRESS 106 Irving St. NW, Washington, D.C. 20010				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/9/87		23c. NAME OF CEMETERY OR CREMATORY Ivy Hill Cemetery		23d. LOCATION Laurel P.G. Md.		
24. FUNERAL DIRECTOR NAME ADDRESS 7601 Sandy Spring Road Fleck Funeral Home, Inc. Laurel, Md. 20708				25a. DATE REC'D. BY REGISTRAR OCT 13 1987				
				25b. REGISTRAR'S SIGNATURE Julia B. [Signature]				

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

30227

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Clarence Permain BREWER			2a DATE OF DEATH MONTH DAY YEAR October 26, 1987		2b HOUR 5:47P M
3 SEX Male	4 RACE Caucasian	5 DATE OF BIRTH MONTH DAY YEAR Aug. 17, 1920		6 AGE (IN YEARS LAST BIRTHDAY) 67 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
10 CITY OR TOWN OF DEATH Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Model Maker	12b KIND OF BUSINESS OR INDUSTRY U.S. Gov't.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland 13b COUNTY Anne Arundel 13c CITY OR TOWN Harwood			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 4748 -L Flanders Ln., 20776	
14 FATHER'S NAME FIRST MIDDLE LAST Clarence P. Brewer			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Stella F. Phillips		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW-2	17 INFORMANT ADDRESS Arletta A. Brewer, Same as Line #13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>PULMONARY EMBOLISM</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>INTRAMURAL THROMBUS RIGHT HEART</u>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>MYELO PROLIFERATIVE DISEASE</u>					
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 6, PART 5 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)	21f LOCATION CITY OR TOWN COUNTY STATE			
22a I certify that (1) (this hospital) attended the deceased from <u>10-26</u> , 19 <u>87</u> , to <u>10-26</u> , 19 <u>87</u> that (1) (we) last saw the deceased alive on <u>10-18</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) not view the body after death.					
22b SIGNATURE <u>Hema Yadla</u>			DEGREE M.D.	22c DATE SIGNED 10/27/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Hema Yadla M.D.			22e ADDRESS 9470 Annapolis Rd., Lanham, Md. 20706		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 10-30-87	23c NAME OF CEMETERY OR CREMATORY Md. Veterans Cemetery Cheltenham, P.G., Maryland		23d LOCATION CITY OR TOWN COUNTY STATE	
24 FUNERAL DIRECTOR FRANCIS GASCHS SONS FUNERAL HOME, P.A. 4739 Baltimore Ave., Hyattsville, Maryland			25a DATE REC'D BY REGISTRAR NOV 4 1987		
			25b REGISTRAR'S SIGNATURE Julia Davidson-Randall		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Medical Examiner Notified - Released to PMD

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) GABRIEL Paul Brinsky			2a DATE OF DEATH MONTH DAY YEAR 10 22 87			2b HOUR 5:30 PM				
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR January 5, 1917		6 AGE (IN YEARS, LAST BIRTHDAY) 70		7b HOUR 5:30 PM		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD				
10 CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Attorney - Ret.		12b KIND OF BUSINESS OR INDUSTRY Attorney				
13a STATE Maryland			13b COUNTY Prince George		13c CITY OR TOWN Ft. Washington		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 12415 Parkton St. 20744	
14 FATHER'S NAME FIRST MIDDLE LAST Sigmund Brinsky			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Martiak							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17 INFORMANT Marie Brinsky		ADDRESS 12415 Parkton St. Ft. Washington, Md.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIOVASCULAR Arrest & failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Post-Pulmonary Embolism S.M.I. (c) Pulmonary Embolism									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Leukemia										
19a DATE OF OPERATION 10/20/87			19b CONDITION FOR WHICH OPERATION WAS PERFORMED Colon Carcinoma			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18b PART I OR PART 2)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22 I certify that (1) (this hospital) attended the deceased from 10/14/87, 1987, to 10/22, 1987, that (1) saw the deceased alive on 10/21, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) view the body after death.										
22b SIGNATURE GARY S. GROVER						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10/22/87		
22d PHYSICIAN'S NAME (TYPE OR PRINT) GARY S. GROVER						22e ADDRESS 7501 Surratts Rd. #104, Clinton, Maryland				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 10/26/87		23c NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Silver Spring Mont. Md.			
24 FUNERAL DIRECTOR NAME George P. Kalas Funeral Home						ADDRESS Oxon Hill, Md.		25a DATE REC'D. BY REGISTRAR OCT 27 1987		
25b REGISTRAR'S SIGNATURE										

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

68718. OCT 15 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

30227

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) WAYNE COURTNEY BROMLEY, Sr.			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 6 1987			2b. HOUR 9:00P M				
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR October 29, 1920		6 AGE (IN YEARS LAST BIRTHDAY) 66		7. MINOR YEAR MONTH DAY HOUR MIN. YRS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD				
10 CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors Hospital of Pr. Geo. Co.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter		12b. KIND OF BUSINESS OR INDUSTRY Decorating		
13a. STATE Maryland			13b. COUNTY P.G.		13c. CITY OR TOWN New Carrollton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7869 Riverdale Road 20784	
14 FATHER'S NAME William Owen			15 MOTHER'S MAIDEN NAME Mamie Kline			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				
16b. SOCIAL SECURITY NO. 578-20-6650			17 INFORMANT ADDRESS 7869 Riverdale Road Betty V. Bromley (Wife) New Carrollton, Md. 20784							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) CARCINOMA OF R. LUNG DUE TO, OR AS A CONSEQUENCE OF (c) SEPSIS OF LEFT LUNG APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET 6470 Annapolis Road		21g. CITY OR TOWN Lanham		
21h. COUNTY M.D.			21i. STATE Maryland		21j. ZIP CODE 20706					
22a. I certify that (I) (this hospital) attended the deceased from 9-28 19 87 to 10-6 19 87 that (I) (we) last saw the deceased alive on 10-6 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death										
22b. SIGNATURE A. Pourhamidi, MD						22c. DATE SIGNED 10-8-87		22d. PHYSICIAN'S NAME (TYPE OR PRINT) POURHAMIDI, ABOL		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/12/87		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland			
24. FUNERAL DIRECTOR Francis Casch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781						25a. DATE REC'D. BY REGISTRAR OCT 14 1987				
25b. REGISTRAR'S SIGNATURE J. L. Davidson-Rodell										

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

BP

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100 12 91

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG NO				
1 DECEASED NAME (TYPE OR PRINT) Mary S Brooks					2a DATE OF DEATH MONTH 10 DAY 3 YEAR 87				
3 SEX F		4 RACE Black		5 DATE OF BIRTH MONTH 04 DAY 27 YEAR 10		6 AGE (IN YEARS LAST BIRTHDAY) 77 YRS		2b HOUR 6:07 PM	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD			
10 CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospita				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY HOSPITAL	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Md. COUNTY 13b		13c CITY OR TOWN Annapolis		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 912 Smithville St. 21401			
14 FATHER'S NAME FIRST James MIDDLE Snowden LAST		15 MOTHER'S MAIDEN NAME FIRST Jane MIDDLE Parker LAST							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS Mary J. Marbray Box 175 Bryan Rd.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage upper Gastrointestinal Remnantage DUE TO, OR AS A CONSEQUENCE OF (b) Unresectable Pancreatic Cancer DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 3 mos 3 days									
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from August 19 87 to October 19 87 that (I) (we) last saw the deceased alive on 10-3-87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Kai-Yin Young					DEGREE			22c DATE SIGNED 10-4-87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Kai-Yin YOUNG, MD					22e ADDRESS 8926 Woodyard Rd #201 Clinton MD 20735				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10-8-1987		23c NAME OF CEMETERY OR CREMATORY Mill Crest Ceme.		23d LOCATION CITY OR TOWN Annapolis A.A. Md. COUNTY STATE			
24 FUNERAL DIRECTOR William Reese & Sons Mortuary, P.A.					25a DATE REC'D BY REGISTRAR OCT 06 1987 25b REGISTRAR'S SIGNATURE John Swinson-Randall				

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT)		STANLEY R. BROOKS		2a DATE OF DEATH MONTH DAY YEAR		10-14-87		2b HOUR 9:10AM	
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR		Jan. 27, 1917		6 AGE (IN YEARS LAST BIRTHDAY) 70	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Unseith N.D.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD			
10 CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE'S GEORGE'S HOSPITAL CENTER		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret.		12b KIND OF BUSINESS OR INDUSTRY U.S. Govt.			
13a STATE Maryland		13b COUNTY P. G.		13c CITY OR TOWN Upper Marlboro		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 5207 Mapleshade Lane 20772	
14 FATHER'S NAME FIRST MIDDLE LAST Roy E. Brooks		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hazel E. Harris		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No N/A					
16b SOCIAL SECURITY NO 579-10-6308		17 INFORMANT Gladys C. Brooks				17 ADDRESS Same as 13 A-E			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CHRONIC MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>SCARS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>INFECTED AORTIC VALVE</u>									
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a DATE OF OPERATION 3/1/87		19b CONDITION FOR WHICH OPERATION WAS PERFORMED Bleeding from Aortic Valve		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <u>3/1</u> 19 <u>87</u> to <u>10/14</u> 19 <u>87</u> that (I) (we) lost saw the deceased alive on <u>10/14</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <u>[Signature]</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10/14/87			
22d PHYSICIAN'S NAME (TYPE OR PRINT) BAXN'S BAYLY MD		22e ADDRESS 3701 Medical Terrace Chevy Md							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE 10/15/87		23c NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d LOCATION CITY OR TOWN COUNTY STATE Clinton Prince George's Md.			
24 FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.		25a DATE REC'D. BY REGISTRAR OCT 21 1987		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a medical certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 showing any injury or other traumatic event, the medical examiner must be notified at once.

067264 OCT

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
 1. NOTIFY THE MEDICAL EXAMINER, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR
 2. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGE 2 AND 2 SHOULD BE FILED, WITHIN 72 HOURS
 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,
 BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07 84
25M

DHMH 17
(VR A15 ME (5))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
REG. NO.									
1 DECEASED NAME (TYPE OR PRINT) Anthony G. Brown									
2a DATE KNOWN OF DEATH EST. MATED 9-17 19 87									
3 SEX Male 4 RACE Black 5 DATE OF BIRTH MONTH DAY YEAR March 16, 1971 6 AGE (IN YEARS) (LAST BIRTHDAY) 16 7c DATE PRONOUNCED DEAD 9-17 19 87 7d HOUR 6:54									
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. 7b CITIZEN OF WHAT COUNTRY? U.S.A. 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's County									
10 CITY OR TOWN OF DEATH Cheverly 11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN HEALTH FACILITY, GIVE STREET ADDRESS) Prince Georges General Hospital 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student 12b KIND OF BUSINESS OR INDUSTRY School									
13a STATE Md. 13b COUNTY P.G. 13c CITY OR TOWN Cheverly 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e STREET ADDRESS 3501 56th Pl. 20784									
14 FATHER'S NAME FIRST MIDDLE LAST Clarence Parker 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Yolanda Brown									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No 16b SOCIAL SECURITY NO. 579-82-7050 17 INFORMANT ADDRESS Yolanda B. Stokes-Same as # 13									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Propoxyphene and acetaminophen intoxication DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1									
19a DATE OF OPERATION 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? 20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 9 19 87 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM #8 PART 1 OR PART 2) Ingestion of drugs									
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK 21e PLACE OF INJURY (AT HOME STREET FACTORY, FARM, ETC.) unknown 21f LOCATION STREET CITY OR TOWN COUNTY STATE Prince Georges Co. Maryland									
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>									
ACTUAL SIGNATURE Margaret A. Korell M.D. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 9-18-87									
EXAMINER'S NAME (TYPE OR PRINT) Margaret A. Korell, M.D. ADDRESS 111 Penn Street, Balto., MD 21201									
23a BURIAL, CREMATION, REMOVAL (WHERE?) 23b DATE 9/25/87 23c NAME OF CEMETERY OR CREMATORY WASHINGTON NAT'L CEM. SCITLAND P.G. MD. 23d LOCATION CITY OR TOWN COUNTY STATE									
24 FUNERAL DIRECTOR NAME ADDRESS H. S. WASHINGTON & SONS 4925 BURNING AVE SEP 29 1987 25a DATE REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE									

SEP 29 1987

Black, John H. 1911-19

U.S.A.

John H. Black

John H. Black

John H. Black

John H. Black



John H. Black

John H. Black

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7-B4
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

2a. DATE OF DEATH MONTH DAY YEAR 10-25-87			2b. HOUR 7.00PM M		
3 SEX FEMALE		4 RACE BLACK		5 DATE OF BIRTH AUG 21 1910	
6 AGE (IN YEARS (LAST BIRTHDAY)) 76 YRS		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN		8 UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON D.C.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9a CITY OR TOWN OF DEATH CHEVERLY		9b NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGES HOSPITAL CENTER		9c BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD	
10 CITY OR TOWN OF DEATH CHEVERLY		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGES HOSPITAL CENTER		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	
12b KIND OF BUSINESS OR INDUSTRY NONE		13a STATE M.D.		13b COUNTY P.G.	
13c CITY OR TOWN CAPT HTS.		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 835 EASTERN AVE. 20740	
14 FATHER'S NAME FIRST MIDDLE LAST DORSEY GRAY		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JOSEPHINE GRAY		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) NO	
16b SOCIAL SECURITY NO 579-24-6666		17 INFORMANT JEFFREY WINTERS		18 ADDRESS 835 EASTERN AVE CAPITOL HTS. MARYLAND	
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <u>Chronic Obstructive Pulmonary Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (1) this hospital attended the deceased from 10-24 1987 to 10-25 1987, that (2) we last saw the deceased alive on 10-25 1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death)					
22b SIGNATURE <u>Louis Steinberg</u> MD				22c DATE SIGNED 10-25-87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Louis Steinberg				22e ADDRESS 6492 Landover Rd Landover, Md	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE 10-28-87		23c NAME OF CEMETERY OR CREMATORY HARMONY CEMETERY	
23d LOCATION LANDOVER P.G. MARYLAND		24 FUNERAL DIRECTOR NAME ROLLINS FUNERAL HOME, INC. 4339 HUNT PLACE, N.E. WASHINGTON, D.C. 20019		25a DATE REC'D. BY REGISTRAR NOV 02 1987	
25b REGISTRAR'S SIGNATURE Julia Tindon-Rudman					

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070061 OCT 29 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

FOR
STATE
REGISTRAR

1- DECEASED NAME
(TYPE OR PRINT)

Donald

Brown

2a DATE KNOWN OF DEATH ESTI MATED ☒ MONTH DAY YEAR 10 24 19 87 2b HOUR 5 PM

3 SEX

4 RACE

5 DATE OF BIRTH

6 AGE (IN YEARS)

IF UNDER 1 YR

IF UNDER 24 HRS

7c DATE PRONOUNCED DEAD

MONTH DAY YEAR 10 24 19 87

2d HOUR 5 PM

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

WASHINGTON, D.C.

7b CITIZEN OF WHAT COUNTRY?

USA

8 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Prince George's County, MD

10 CITY OR TOWN OF DEATH

Riverdale

11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Leland Memorial Hospital

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

METER REPAIRMAN

12b KIND OF BUSINESS OR INDUSTRY

GOV'T

13a USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

DC

13b COUNTY

13c CITY OR TOWN

WASHINGTON

13d INSIDE CITY LIMITS?

YES ☒ NO ☐

13e STREET ADDRESS

1173-46th PLACE, S.E.

14 FATHER'S NAME

DONALD

MIDDLE

F.

LAST

BROWN

15 MOTHER'S MAIDEN NAME

WILLIE MAE

MIDDLE

CARTER

LAST

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)

NO

16b SOCIAL SECURITY NO.

579-64-2244

17 INFORMANT

SHARON LEE BROWN

ADDRESS

4111-51st STREET, #102

BLADENSBURG, MD

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Pulmonary embolus

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED?

20 AUTOPSY?

YES ☒ NO ☐21a EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR

P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK ☐ AT WORK ☐

21e PLACE OF INJURY (AT HOME STREET FACTORY FARM, ETC.)

21f LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a I certify that I took charge of the remains described above and on

Autopsy ☒Inspection ☐Inquiry ☐

and in my opinion

death resulted from

Natural causes ☒Accident ☐Suicide ☐Homicide ☐Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (TYPE OR PRINT)

Dennis F. Smyth, M.D.

ADDRESS

111 Penn St.

Balto.MD.

23a BURIAL, CREMATION, REMOVAL (SPECIFY)

BURIAL

23b DATE

10-29-87

23c NAME OF CEMETERY OR CREMATORY

FORT LINCOLN

23d LOCATION (CITY OR TOWN)

BLADENSBURG, PG

COUNTY

PG

STATE

MD

24 FUNERAL DIRECTOR NAME

ALEXANDER S. POPE

ADDRESS

2617 PENNA., AVE., S.E.

25a DATE REC'D BY REGISTRAR

OCT 28 1987

25b REGISTRAR'S SIGNATURE

Lia Tisdell-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

DHMH - 17
(VR A15 ME (5))

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

30235

REG NO

1- FOR
STATE
REGISTRAR

DECEASED NAME (PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR				2b HOUR			
FRANK B. BROWN						10 29 87				9 ⁵⁵ A M			
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)		7 UNDER YEAR		7 UNDER 2 HRS		
MALE		WHITE		10 27 1901			86 YRS						
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH				
Maryland			USA						Prince Georges			MD	
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY				
Adelphi			Hillbarn Nursing Center			Elevator Construction			ELEVATOR				
13a STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE				
Md.			P. G.		Takoma Park				4305 15th Pl. Takoma Park, Md.			20912	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME										
Joseph Morgan Brown			Mary Louise Gorman										
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17 INFORMANT							
NO			NONE			578-07-8121			HARVEY T. JACKSON, SR.			Simeas #13	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY			
IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u>			
DUE TO, OR AS A CONSEQUENCE OF			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
(b) <u>METASTATIC CARCINOMA</u>			
DUE TO, OR AS A CONSEQUENCE OF			
(c) _____			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR	
		P.M. 19	
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)	
		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (1) this hospital attended the deceased from <u>April 19 86</u> to <u>10-29-87</u> that (2) I have lost saw the deceased alive on <u>10-29-87</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) we (I) did not view the body after death.			
22b SIGNATURE <u>Charles Benner MD</u>		DEGREE	
22c DATE SIGNED <u>10-29-87</u>			
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>CHARLES BENNER MD</u>		22e ADDRESS <u>11161 NEW HAMPSHIRE AVE SILVER SPRING MD 20904</u>	

23a BURIAL, CREMATION, REMOVAL (SPECIFY) <u>CREMATION</u>		23b DATE <u>OCT 30, 1987</u>		23c NAME OF CEMETERY OR CREMATORY <u>CHAMBERS CREMATORY</u>		23d LOCATION CITY OR TOWN COUNTY STATE <u>PRINCE GEORGES CO. MARYLAND</u>	
24 FUNERAL DIRECTOR NAME <u>CHAMBERS FUNERAL HOME</u> ADDRESS <u>SILVER SPRING, MD.</u>				25 INTERVIEWED BY (NAME, ADDRESS, CITY, STATE, ZIP) <u>NOV 03 1987</u>			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. These permits are required on all burials. They must be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR
DISEASED NAME
(TYPE OR PRINT)

FIRST MIDDLE LAST
James Wilmer Brown

2a DATE KNOWN OF DEATH ESTI MATED *10-7-87*
7c DATE PRONOUNCED DEAD *10-9-87*

3 SEX *Male* 4 RACE *Black* 5 DATE OF BIRTH MONTH DAY YEAR *11-1-13* 6 AGE (IN YEARS) (LAST BIRTHDAY) *73 YRS.* IF UNDER 1 YR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) *Oxon Hill* 7b CITIZEN OF WHAT COUNTRY? *U.S.* 8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 9 BALTIMORE CITY OR COUNTY OF DEATH *Oxon Hill P.G. md.*

10 CITY OR TOWN OF DEATH *Oxon Hill* 11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IS NOT IN THIS FACILITY, GIVE STREET ADDRESS) *1313 Southern Avenue* 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) *Retired Cook* 12b KIND OF BUSINESS OR INDUSTRY *Navy Dept.*

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE *Maryland* 13b COUNTY *PG* 13c CITY OR TOWN *Oxon Hill* 13d INSIDE CITY LIMITS? YES ☒ NO ☐ 13e STREET ADDRESS *1313 Southern Avenue*

14 FATHER'S NAME FIRST MIDDLE LAST *George M. Simms* 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST *Estella Brown*

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) *No* 16b SOCIAL SECURITY NO. *577-89-7622* 17 INFORMANT *Lauretta Brown* ADDRESS *2633 Pomroy Rd. SE*

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY *Diabetic astens polio the cardiovascular disease*
IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a *Cro-monal bleeding*

19a DATE OF OPERATION _____ 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? _____ 20 AUTOPSY? YES ☐ NO ☒

21a EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH _____ 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. *19* 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) _____ 21d INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK ☐ AT WORK _____ 21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.) _____ 21f LOCATION STREET CITY OR TOWN COUNTY STATE

22a I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE *James P. Phipps* TITLE SPECIFY *Deputy* M.D. *Deputy* MEDICAL EXAMINER DATE SIGNED *10-9-87*
EXAMINER'S NAME (TYPE OR PRINT) *James P. Phipps* ADDRESS _____

23a BURIAL, CREMATION, REMOVAL (SPECIFY) *Burial* 23b DATE *10-15-87* 23c NAME OF CEMETERY OR CREMATORY *Washington National* 23d LOCATION CITY OR TOWN *Switzland* COUNTY *PG* STATE *Maryland*

24 FUNERAL DIRECTOR NAME *Moses Funeral Home* ADDRESS *1661 Good Hope Rd, SE* 25a DATE REC'D BY REGISTRAR *OCT 19 1987* 25b REGISTRAR'S SIGNATURE *John L. ...*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM-PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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James L. White, Jr.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 0 2 3 7

REG NO

1. DECEASED NAME (TYPE OR PRINT) Matilda C. Brown		2a. DATE OF DEATH MONTH DAY YEAR Oct. 10, 1987		2b. HOUR 11:20A M	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 16, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 89	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges' MD	
10. CITY OR TOWN OF DEATH Hyattsville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hyattsville Manor		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home
13a. STATE MD	13b. COUNTY PG	13c. CITY OR TOWN Hyattsville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 6500 Riggs Rd. 20783	
14. FATHER'S NAME FIRST MIDDLE LAST John Crawford		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ellen Dawson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 577-84-0983		17. INFORMANT ADDRESS MD 20817 Phyllis B. Hodson 6204 Stardust La. Beth.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cerebrovascular disease DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18b PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from Nov. 11 19 85 to Oct. 10 19 87 that (I) (we) last saw the deceased alive on Oct. 10 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE Christopher Unger MD				22c. DATE SIGNED Oct. 10, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Christopher Unger				22e. ADDRESS 8218 Wisconsin Ave, Bethesda, MD 20814	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 10/17/87	23c. NAME OF CEMETERY OR CREMATORY Mt. Comfort Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, VA
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. ADDRESS 5130 WI Ave. NW Wash., DC 20016				25a. DATE DECD BY REGISTRAR 25b. REGISTRAR'S SIGNATURE OCT 23 1987 Julia Danden-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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2350 W. 4th Ave. • NW • Wash., D.C. 20037

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

3 0 2 3 8

FOR
STATE
REGISTRAR

DECEASED NAME

FIRST

MIDDLE

LAST

Samuel A. Brown Jr.

2a DATE KNOWN OF DEATH
MONTH DAY YEAR
10-14 1987

2b HOUR
M

3 SEX

4 RACE

5 DATE OF BIRTH

MONTH

DAY

YEAR

6 AGE (IN YEARS)

LAST BIRTHDAY

MONTHS

DAYS

HOURS

MIN

IF UNDER 1 YR.

IF UNDER 24 HRS.

7c DATE

PRONOUNCED

DEAD

MONTH

DAY

YEAR

2d HOUR

M

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

7b CITIZEN OF WHAT COUNTRY?

8 MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

9 BALTIMORE CITY OR COUNTY OF DEATH

MD

10 CITY OR TOWN OF DEATH

11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

12b KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

13b COUNTY

13c CITY OR TOWN

13d INSIDE CITY LIMITS?

YES

NO

13e STREET ADDRESS

14 FATHER'S NAME

15 MOTHER'S MAIDEN NAME

16a WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO, OR UNKNOWN)

16b SOCIAL SECURITY NO.

17 INFORMANT

ADDRESS

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE

DUPLICATE AS A CONSEQUENCE OF

(b)

DUPLICATE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED?

20 AUTOPSY?

YES

NO

21a EXTERNAL CAUSE WAS

UNDERLYING

OR

CONTRIBUTING

CAUSE OF DEATH

21b TIME OF INJURY

HOUR A.M.

MONTH

DAY

YEAR

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d INJURY OCCURRED

WHILE

NOT WHILE

AT WORK

21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)

21f LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a I certify that I took charge of the remains described above, held on

Autopsy

Inspection

Inquiry

and in my opinion

death resulted from

Natural causes

Accident

Suicide

Homicide

Undetermined manner

ACTUAL SIGNATURE

TITLE (SPECIFY)

M.D.

MEDICAL EXAMINER

DATE SIGNED

10-14-87

EXAMINER'S NAME (TYPE OR PRINT)

Augusto P. Rodriguez, M.D.

ADDRESS

5009 Rayburn Ct.

Temple Hills, MD

23a BURIAL, CREMATION, REMOVAL (SPECIFY)

23b DATE

23c NAME OF CEMETERY OR CREMATORY

23d LOCATION

CITY OR TOWN

COUNTY

STATE

24 FUNERAL DIRECTOR

NAME

ADDRESS

25a DATE REC'D. BY REGISTRAR

25b REGISTRAR'S SIGNATURE

25c DATE REC'D. BY REGISTRAR

25d REGISTRAR'S SIGNATURE

25e DATE REC'D. BY REGISTRAR

25f REGISTRAR'S SIGNATURE

25g DATE REC'D. BY REGISTRAR

25h REGISTRAR'S SIGNATURE

25i DATE REC'D. BY REGISTRAR

25j REGISTRAR'S SIGNATURE

25k DATE REC'D. BY REGISTRAR

25l REGISTRAR'S SIGNATURE

25m DATE REC'D. BY REGISTRAR

25n REGISTRAR'S SIGNATURE

25o DATE REC'D. BY REGISTRAR

25p REGISTRAR'S SIGNATURE

25q DATE REC'D. BY REGISTRAR

25r REGISTRAR'S SIGNATURE

25s DATE REC'D. BY REGISTRAR

25t REGISTRAR'S SIGNATURE

25u DATE REC'D. BY REGISTRAR

25v REGISTRAR'S SIGNATURE

25w DATE REC'D. BY REGISTRAR

25x REGISTRAR'S SIGNATURE

Robert G. Moser

1661 Good Hope Rd, SE

OCT 19 1987

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL. TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE USED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
VRA 15 ME 15

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[Faint, illegible handwriting throughout the page]



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070957 NOV - 87

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 0 2 3 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WILLIAM EUGENE BROWN			2a. DATE OF DEATH MONTH DAY YEAR OCT 31 87			2b. HOUR 12:47am			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Feb. 23, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 71		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (COUNTRY) Iowa		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges' Co. MD			
10. CITY OR TOWN OF DEATH Andrews A.F.B.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Malcolm Grow Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Musician		12b. KIND OF BUSINESS OR INDUSTRY Military			
13a. STATE Maryland		13b. COUNTY Prince Georges Bowie		13c. CITY OR TOWN YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE 2402 Belair Dr. 20715	
14. FATHER'S NAME FIRST MIDDLE LAST William Wise Brown			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Marie Hansen						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes		16b. SOCIAL SECURITY NO 569-36-5702		17. INFORMANT ADDRESS Gertrude W. Brown (wife) Same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>MULTI-SYSTEM FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18b, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <u>31 OCT 87</u> to <u>31 OCT 87</u> that (I) (we) last saw the deceased alive on <u>31 OCT 87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Michael P. McGunigal</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 31 Oct 87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) McGunigal, MICHAEL P.				22e. ADDRESS MGMC/ARFB, Md 20331					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 2 Nov 87		23c. NAME OF CEMETERY OR CREMATORY Uniformed Services University of the Health Sciences, Bethesda, MD		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME Capitol Funeral Service, Falls Church, VA				25a. DATE REC'D. BY REGISTRAR NOV 05 1987		25b. REGISTRAR'S SIGNATURE <i>John D. Anderson</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 only to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

070327 101-861

TO:

CHANDLER

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FROM:

U.S.A.

100-100-100

SUBJECT:

100-100-100

REFERENCE:

100-100-100

REMARKS:

100-100-100

DATE:

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INITIALS:

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

FOR
1 - STATE
REGISTRAR

068770 OCT 16 1987

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LOTTIE BUCKNER		2a DATE OF DEATH MONTH DAY YEAR 09 30 87		2b HOUR 2:25 PM	
3 SEX FEMALE	4 RACE BLACK	5 DATE OF BIRTH MONTH DAY YEAR 9 3 1900		6 AGE (IN YEARS LAST BIRTHDAY) 87 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH CHEVERLY, MD - PGC MD	
10 CITY OR TOWN OF DEATH Cheverly	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES COMM. HOSP		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED - DOMESTIC WORKER		12b KIND OF BUSINESS OR INDUSTRY
13a STATE MD.		13b COUNTY PG	13c CITY OR TOWN FAIRMONT HILLS	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Albert Proctor		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Swann			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO 719-03-1808		17 INFORMANT Juletha Braxton	
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) CVA / SEPSIS DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a MULT CVA's DM, RTA - Renal Insufficiency					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 9/21 19 87 , to 9/30 19 87 , that (I) (we) last saw the deceased alive on 9/30 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Sandra Y. Robinson-Reedway		DEGREE MD		22c DATE SIGNED 9/30/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) SANDRA Y. ROBINSON-REOWAY		22e ADDRESS PRINCE GEORGES HOSPITAL			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 10-7-87	23c NAME OF CEMETERY OR CREMATORY MT Olivet Cem.		23d LOCATION CITY OR TOWN COUNTY STATE Wash. D.C.	
24 FUNERAL DIRECTOR NAME Comer-Hodges		ADDRESS 4901 Marlboro Pk. Md.		25a DATE REC'D. BY REGISTRAR OCT 15 1987	
		25b REGISTRAR'S SIGNATURE Julia Davidson-Randall			

Released to H. B. Washington & Sons, Inc. 10/15/87

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove chapter pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file with page 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GEORGE BUTLER		2a. DATE OF DEATH MONTH DAY YEAR 10-01-87		2b. HOUR 2.05A M	
3 SEX Male		4 RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 3 16 1904		6 AGE (IN YEARS LAST BIRTHDAY) 83 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD	
10 CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (GIVE FULL NAME AND STREET ADDRESS) PRINCE GEORGES MEDICAL CENTER		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b KIND OF BUSINESS OR INDUSTRY D.C. Government	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland		13b COUNTY P.G.		13c CITY OR TOWN Capitol Hgts		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas E. Butler		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Harley		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO 220-09-3969	
17 INFORMANT ADDRESS Betty Johnson (Daughter) 5918 Burgundy St. Capitol Hgts. Md.		18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Squamous Cell Bronchogenic Carcinoma</u> 9293 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>Right lung obstructive pneumonia</u> (c) <u>Respiratory failure</u>		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>① Advanced Emphysema. ② Old fracture of Left hip</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 OR PART 2 OR PART 3)		21d LOCATION (CITY OR TOWN COUNTY STATE) Capitol Hgts. P.G. MD	
22a I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 9/30/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did not view the body after death.		22b SIGNATURE SKRINIVAT R. UDAPE		DEGREE MD		22c DATE SIGNED 10/1/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) SKRINIVAT R. UDAPE		22e ADDRESS 6005 LANDOVER RD CHEVERLY, MD		23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10-6-1987	
23c NAME OF CEMETERY OR CREMATORY Harmony Mem. Park		23d LOCATION (CITY OR TOWN COUNTY STATE) Landover, Maryland		24 FUNERAL DIRECTOR Rollins Funeral Home, Inc.		25a DATE REC'D. BY REGISTRAR OCT 8 1987	
25b REGISTRAR'S SIGNATURE Julia Davidson-Pulver		25c REGISTRAR'S SIGNATURE		25d REGISTRAR'S SIGNATURE		25e REGISTRAR'S SIGNATURE	

18-2-100 E-42880

8

068161 OCT-1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

30242

REGISTRAR

REG NO

1 DECEASED NAME (TYPE OR PRINT) DAVID C. BYRD			2a DATE OF DEATH MONTH 10 DAY 01 YEAR 87		2b HOUR 11:02 P
3 SEX Male	4 RACE Caucasian	5 DATE OF BIRTH MONTH April DAY 1 YEAR 1922		6 AGE (IN YEARS (LAST BIRTHDAY)) 65	IF UNDER 1 YEAR MONTHS DAYS
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD	
10 CITY OR TOWN OF DEATH CLINTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital		12a USUAL OCCUPATION (LIPS OF WORK FOR MOST OF WORKING LIFE) Lithographer		12b KIND OF BUSINESS OR INDUSTRY Judd & Detweiler
13 USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland 13b COUNTY P. G. 13c CITY OR TOWN Forestville			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME FIRST Walter MIDDLE C. LAST Byrd		15 MOTHER'S MAIDEN NAME FIRST Elizabeth MIDDLE V. LAST Duncan			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) Yes		16b SOCIAL SECURITY NO (TYPE OR PRINTS) 1941-1945 233-28-6418		17 INFORMANT Marjorie M. Byrd ADDRESS Same as 13 A-E	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Infarction					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 HOUR
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost b) Ischemic Heart Disease					YEARS
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 1) DIABETES MELLITUS 2) UREMIA					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22 I certify that (1) this hospital attended the deceased from 10/15 , 19 87 to 10/2 19 87 that (1) we last saw the deceased alive on 7/8 19 87 , and that in my own opinion death occurred on the date and hour and from the causes stated above, (2) we did not view the body after death.					
22b SIGNATURE Robert NedzBALA				22c DATE SIGNED 10/5/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Robert NEDZBALA, M.D.				22e ADDRESS 11701 LIVINGSTON RD, FT. WASHINGTON MD 20744	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10/05/87		23c NAME OF CEMETERY OR CREMATORY Maryland Veterans Cem	
23d LOCATION (CITY OR TOWN) Cheltenham		23e COUNTY Prince George Md		23f STATE	
24 FUNERAL DIRECTOR NAME Lee Funeral Home, Inc. ADDRESS 133 Old Alexander Ferry Rd Clinton, Md 20735				25a DATE RECD. BY REGISTRAR OCT - 8 1987	
25b REGISTRAR'S SIGNATURE Julia Davidson-Randall					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit permit. Then please remove certain papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 2 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified to be called.

BP

080101 01-907

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DAVID C. BIRD

David C. Bird

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070661 NOV 13 87 10-27-87 per med exam items 18-224, 661 6322 DEPT OF HEALTH AND MENTAL HYGIENE 30243

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) EDWARD D. BYRD			2a DATE KNOWN OF DEATH ESTIMATED X 9 7 19 87			2b HOUR M			
3 SEX Male	4 RACE Black	5 DATE OF BIRTH MONTH DAY YEAR 7- 26- '38	6 AGE (IN YEARS) (LAST BIRTHDAY) 49 YRS	IF UNDER 1 YR MONTHS DATE HOURS MIN	IF UNDER 24 HRS	7c DATE PRONOUNCED DEAD MONTH DAY YEAR 9 11 19 87	7d HOUR 10:20 AM		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD			
10 CITY OR TOWN OF DEATH Oxon Hill		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4545 Wheeler Rd.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Management Engineer		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE Maryland			13b COUNTY Prince George Oxon Hill	13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES X NO <input type="checkbox"/>			13e STREET ADDRESS 4545 Wheeler Road 20745
14 FATHER'S NAME FIRST MIDDLE LAST Herbert Byrd				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sally Lewis					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 2-1 '72 8- '75		17 INFORMANT ADDRESS daughter 58 Henderson Ave. Andrea Byrd-Brown Havelock NC					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) FATTY LIVER NATURAL. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?					20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> and in my opinion									
ACTUAL SIGNATURE Dennis F. Smyth, M.D.			TITLE (SPECIFY) MEDICAL EXAMINER			DATE SIGNED 9-12-87			
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.			ADDRESS 111 Penn St., Balto., MD 21201						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 16Sept 87		23c NAME OF CEMETERY OR CREMATORY Arlington National		23d LOCATION CITY OR TOWN COUNTY STATE Arlington, Virginia		
24 FUNERAL DIRECTOR NAME Latney's			ADDRESS 3831 Georgia Aven. N. W.			25a DATE REC'D BY REGISTRAR OCT 21 1987		25b REGISTRAR'S SIGNATURE The Davidson-Pondell	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

100-100-100



Items 5, 6, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

FOR
1 - STATE
REGISTRAR

2 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROSEMARIE CLARK CAMPANELLO			2a DATE OF DEATH MONTH DAY YEAR 10-21-87		2b HOUR 5 00AM	
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR June 16, 1921		
6 AGE (IN YEARS LAST BIRTHDAY) 60 -66 YRS		7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b CITIZEN OF WHAT COUNTRY? U.S.A.		
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.				
10 CITY OR TOWN OF DEATH CHEVERLY		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGE'S HOSPITAL CENTER		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		
12b KIND OF BUSINESS OR INDUSTRY Home		13a STATE North Carolina		13b COUNTY Craven		
13c CITY OR TOWN Havelock		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 310B East Main St. 28532		
14 FATHER'S NAME FIRST MIDDLE LAST James Joseph Clark		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Hardin				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO 234-32-7214		17 INFORMANT (daughter) Donna Jean Hines		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiovascular arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Metastatic Cancer of the lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Postobstructive Pulmonary Emphysema & Heart Failure</u>		PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21b PART 2 OR PART 1)		21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		
21f LOCATION STREET CITY OR TOWN COUNTY STATE		22a I certify that (I) (his) hospital attended the deceased from 19 86 to 10/20 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b SIGNATURE Robert J. Geroge M.D.		
22c DATE SIGNED 10/21/87		22d PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT J GERARGE		22e ADDRESS 4610 74th Ave Landover Hills MD 20786		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Oct. 24, 1987		23c NAME OF CEMETERY OR CREMATORY Greenleaf Memorial Park, New Bern, North Carolina		
23d LOCATION CITY OR TOWN COUNTY STATE		24 FUNERAL DIRECTOR NAME Capitol Funeral Service, Falls Church, VA		25a DATE REC'D BY REGISTRAR OCT 26 1987		
25b REGISTRAR'S SIGNATURE Jana Burdon		25c REGISTRAR'S NAME Jana Burdon		25d REGISTRAR'S ADDRESS		

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3024

FOR
STATE
REGISTRAR

REG. NO.

069329 OCT 22 1987

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HATTYE J. CAMPBELL			2a. DATE OF DEATH MONTH DAY YEAR 10 13 87		2b. HOUR 7⁵⁵ AM
3. SEX F female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 12 10 06		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Norfolk, Va.	7b. CITIZEN OF WHAT COUNTRY? Us.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.	
10. CITY OR TOWN OF DEATH LAUREL	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GREATER LAUREL BELTSVILLE HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE MARYLAND	13b. COUNTY HOWARD	13c. CITY OR TOWN JESSUP	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 7721 SHARWOOD 20794	
14. FATHER'S NAME FIRST MIDDLE LAST James A. German		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNKNOWN	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) n/a	17. INFORMANT 9130 Vollmerhausen Rd. Thomas Campbell Savage, Md. 20763			

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIOPULMONARY arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause or stating the underlying cause last (b) ISCHEMIC CARDIOMYOPATHY		years
DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY ARTERY DISEASE		years

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c)

19a. DATE OF OPERATION NONE	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NONE	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR NONE P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from OCTOBER 9 1987 to OCTOBER 13 1987 , that it was lost saw the deceased alive on OCTOBER 12 1987 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Eric Tannenbaum		DEGREE MD	22c. DATE SIGNED 10/13/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ERIC TANNENBAUM		22e. ADDRESS 11085 LILIE PARKWAY PKY, Columbia, Md 21044	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10/15/87	23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cem.	23d. LOCATION Jessup Howard Md.
24. FUNERAL DIRECTOR NAME FLORIAN FUNERAL HOME		25a. DATE REC'D. BY REGISTRAR OCT 20 1987	
25b. REGISTRAR'S SIGNATURE Laurel, Maryland			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. The funeral director should be notified by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should be notified by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should be notified by the funeral director, page 3 should be detached for use as the burial-transit permit.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

30240

FOR
1. STATE
REGISTRAR

REG. NO.

2. DECEASED NAME (PRINT) FIRST MIDDLE LAST MELBA J. CANDLAND			2a. DATE OF DEATH MONTH DAY YEAR OCT. 30, 1987		2b. HOUR 1:30 P.M.
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR JULY 31, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) UTAH	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES CO. MD	
10. CITY OR TOWN OF DEATH GREENBELT	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7724 HANOVER PARKWAY #201		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
13a. STATE Md.	13b. COUNTY P.G.C.	13c. CITY OR TOWN GREENBELT	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 7724 HANOVER PARKWAY #201 20770	
14. FATHER'S NAME FIRST MIDDLE LAST ABRAHAM MARTIN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARCHA EMMA WHITING			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 550-24-5182A		17. INFORMANT JACK E. CANDLAND (SAME AS ITEM #13)	
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c. PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Heart failure</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Emphysema severe</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <u>10/30</u> 19 <u>87</u> to <u>10/30</u> 19 <u>87</u> that I have last saw the deceased alive on <u>10/30</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, did not view the body after death)					
22b. SIGNATURE <u>Dr. T. Chanchien</u>		DEGREE <u>MD</u>		22c. DATE SIGNED 19 <u>87</u> <u>10/30</u>	
22d. PHYSICIAN'S NAME (TYPE PRINT) DR. T. CHANCHIEN		22e. ADDRESS <u>824 Cunningham Drive Prince Georges Hydr</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION	23b. DATE 10-31-1987	23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY		23d. LOCATION (CITY OR TOWN COUNTY STATE) RIVERDALE, P.G.C. Md.	
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO.		ADDRESS RIVERDALE, Md. 20737		25a. DATE REC'D. BY REGISTRAR NOV 3 1987	
		25b. REGISTRAR'S SIGNATURE <u>Donald R. Rude</u>			

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068898 OCT 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FRANCIS DE SALES CANTER		2a DATE KNOWN OF DEATH MONTH DAY YEAR 10-13 1987		2b HOUR M
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR 11-24-97	6 AGE (IN YEARS) (LAST BIRTHDAY) 89 YRS.	7 IF UNDER 1 YR. MONTHS DAYS 89
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9 DATE PRONOUNCED DEAD MONTH DAY YEAR 10-13 1987		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES		10 HOUR M
10 CITY OR TOWN OF DEATH CHEVERLY		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEO. GENERAL HOSP.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FARMER
12b KIND OF BUSINESS OR INDUSTRY TOBACCO		13a STATE MD.		13b COUNTY CHARLES
13c CITY OR TOWN WALDORF		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS RT 1 BOX 164
14 FATHER'S NAME FIRST MIDDLE LAST SAMUEL CANTER		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NINA CANTER		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 217-36-9192		17 INFORMANT ADDRESS 3604 Varnum St. 20722 Rosana C. Northover, Brentwood, Md.
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE OF DEATH DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic cerebrovascular disease Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				
PART 7 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I Chronic obstructive pulmonary disease, seizure disorder, dementia				
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE Augusto P. Rodriguez		TITLE (SPECIFY) Deputy		DATE SIGNED 10-14-87
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.		ADDRESS 5009 Rayburn Ct, Temple Hills, MD		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b DATE 10-16-87	23c NAME OF CEMETERY OR CREMATORY ST. MARYS CEMETERY	23d LOCATION CITY OR TOWN COUNTY STATE AQUASCO, P.G., MD.	
24 FUNERAL DIRECTOR NAME HUNT FUNERAL HOME, WALDORF, MD. 20601		25a DATE REC'D BY REGISTRAR OCT 16 1987		
		25b REGISTRAR'S SIGNATURE Julia Dawson-Rudolph		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT, PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07-84
25M

BP

DHMM - 17
(VR A15 ME (15))

060808 OCT 10 11

RECEIVED OCT 10 11



69141 OCT 20 87

30248

STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL-HYGIENE
 CERTIFICATE OF DEATH

FOR
 STATE
 REGISTRAR

REG NO

1 DECEASED NAME (TYPE OR PRINT)			2a DATE OF DEATH			2b HOUR		
FIRST MIDDLE LAST Clarence L. Carr			MONTH DAY YEAR October 16, 1987			8:30AM		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Male	Caucasian	MONTH DAY YEAR 4 1 08	79			YRS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH	
West Virginia		USA		Prince George			MD	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY
Clinton		Southern Maryland Hospital Center			Steelworker - Ret.			Steel
13a STATE			13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET ADDRESS / ZIP CODE		
West Virginia			Tucker	Hendricks	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	R. D. 1 99999		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST Jessie A. Carr			FIRST MIDDLE LAST Virginia Carr					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17 INFORMANT ADDRESS		
Yes			WWII			235-14-1617 Wanda Whetzel 7102 Abbingdon Dr. Oxon Hill, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia								
DUE TO, OR AS A CONSEQUENCE OF (b) Cancer of the Lung								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Congestive Heart Failure								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (1) (this hospital) attended the deceased from 6/8/1987 to 10/16/1987 that (1) two lost soul the deceased alive on 10/15/1987, and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (1) has not (did not) view the body after death.								
22b SIGNATURE						DEGREE		22c DATE SIGNED
Philip Wisotsky, M.D.						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		10/16/87
22d PHYSICIAN'S NAME (TYPE OR PRINT)						22e ADDRESS		
Philip Wisotsky, M.D.						6188 Oxon Hill Rd. Oxon Hill, Md. 20745		
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE	23c NAME OF CEMETERY OR CREMATORY			23d LOCATION CITY OR TOWN COUNTY STATE	
Removal			10/16/87	Brights Chapel Cem.			Hendricks Tucker W. Va.	
24 FUNERAL DIRECTOR NAME				25a DATE RECEIVED BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
George P. Kalas Funeral Home Oxon Hill, Md.				OCT 19 1987		[Signature]		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours of other death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH 16 60M 7/84
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Released to PMD by Medical Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpages. Pages 3 and 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (PRINT) FIRST MIDDLE LAST DAVID YOUNG CARTER			2a. DATE OF DEATH MONTH DAY YEAR October 15 1987		2b. HOUR 10:32A _M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 12, 1912 ^{AR}	6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.		
10. CITY OR TOWN OF DEATH Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co.		12a. USUAL OCCUPATION (IF DECEASED OR PREVIOUSLY WORKING LIFE) Postal Worker	12b. KIND OF BUSINESS OR INDUSTRY Postal Service	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY P.G.	13c. CITY OR TOWN Mt. Rainier	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 4202 29th Street 20712	
14. FATHER'S NAME FIRST MIDDLE LAST Paul David Carter		15. MOTHER'S MAIDEN NAME MIDDLE FIRST LAST Mabel Gwendolyn Young			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes-Navy		16b. SOCIAL SECURITY NO. (IF KNOWN, GIVE WAR DATES) W.W. II	17. INFORMANT ADDRESS David W. Carter (Son) Bowie, Md. 20715		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ischemic Endomyopathy</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Severe coronary artery disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>10/12/87</u> to <u>10/12/87</u> that (I) (we) lost saw the deceased alive on <u>10/12/87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>[Signature]</u> M.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/16/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ABRAHAM DABELA M.D.		22e. ADDRESS 4404 Queensbury Rd Riverdale MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10/19/87	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland		
24. FUNERAL DIRECTOR NAME ADDRESS Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781			25a. DATE REC'D BY REGISTRAR OCT 26 1987		

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001 24 01

Medical Examiner Notified

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

068326 OCT 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1. DECEASED NAME (PRINT) MARIA R. CASTRO-LEON			2a. DATE OF DEATH MONTH DAY YEAR 10 03 87		2b. HOUR 1:40AM
3. SEX FEMALE	4. RACE Hispanic	5. DATE OF BIRTH MONTH DAY YEAR 01 04 94		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS	7. UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (COUNTRY) Mexico	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE CO. MD	
10. CITY OR TOWN OF DEATH RIVERDALE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LELAND MEM. HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Concert Singer		12b. KIND OF BUSINESS OR INDUSTRY Music
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13e. STREET ADDRESS / ZIP CODE		
13a. STATE Maryland	13b. COUNTY P.G. Co.	13c. CITY OR TOWN New Carrollton	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	6113 85TH. Ave. / 20784	
14. FATHER'S NAME FIRST MIDDLE LAST Jose - Sanchez		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maria - Uribe			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO 353-14-5393		17. INFORMANT ADDRESS Maria T. Parcels Same as # 13	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <u>LEFT INTRACEREBRAL HAEMORRHAGE</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (his hospital) attended the deceased on <u>10-2</u> 19 <u>87</u> to <u>10-2</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>10-2</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>R. G. BHOTRAJ MD</u>		DEGREE <u>MD</u>		22c. DATE SIGNED 10-3-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. G. BHOTRAJ		22e. ADDRESS 704 GORMAN AVE T-1. LAUREL, MD 20707			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 10/6/87	23c. NAME OF CEMETERY OR CREMATORY Chambers Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Riverdale P.G. Md.
24. FUNERAL DIRECTOR NAME W.W. Chambers Co. Inc.		ADDRESS Riverdale Md.		25a. DATE REC'D BY REGISTRAR OCT 09 1987	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

BP

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RECEIVED - GENERAL INVESTIGATION DIVISION

OCT 09 1941

U.S. DEPARTMENT OF JUSTICE

WASHINGTON, D.C.

Division of Investigation

Department of Justice

File

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069142 OCT 20 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3025

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Albert Ernest Cepko			2a. DATE OF DEATH MONTH DAY YEAR Oct. 15 1987		2b. HOUR P 11:17 M
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 6 12 22		6. AGE (IN YEARS, LAST BIRTHDAY) 65	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pittsburg, Pa.	7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD	
10. CITY OR TOWN OF DEATH Laurel	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 13301 Avebury Dr. #34		12a. US (Ret.) (TYPE OF WORK FOR MOST OF WORKING LIFE) Steel Worker		12b. KIND OF BUSINESS OR INDUSTRY Industrial
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.			13b. COUNTY P.G.	13c. CITY OR TOWN Laurel	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Emery Cepko			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Makis		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (EXCEPT FOR UNKNOWN) (IF YES, GIVE WAR OR DATES) n/a		16b. SOCIAL SECURITY NO. 188-18-8472		17. INFORMANT ADDRESS Margaret Cepko same as 13e	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) hepatic failure					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1h
DUE TO, OR AS A CONSEQUENCE OF (b) Cancer head neck					h.
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21b, PART 2, OR PART 2)	
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Jan 9, 1977 to Oct 15, 1987 that (I) (we) last saw the deceased alive on 9/21/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I we said) (did not) view the body after death					
22b. SIGNATURE Martin O. Weltz		DEGREE		22c. DATE SIGNED 10/15/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Martin O. Weltz		22e. ADDRESS 7525 Greenway Center Drive Greenbelt MD		22f. LOCATION F.G. MD.	
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial		23b. DATE 10/19/87		23c. NAME OF CEMETERY OR CREMATORY Md. Nat'l Cem.	
23d. LOCATION Laurel		23e. DATE REC'D. BY REGISTRAR OCT 19 1987		23f. REGISTRAR'S SIGNATURE Julia Switzer-Rudness	
24. FUNERAL DIRECTOR ADDRESS 7601 Sandy Spring Rd. Fleck Funeral Home, Inc. Laurel, Md. 20707					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low register that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages may be carbon papers. Pages 1 and 2 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

068778 OCT 15 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Josephine A. Chamberlain			2a DATE OF DEATH MONTH DAY YEAR October 10, 1987		2b HOUR 5:17A
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR July 22, 1903		6 AGE (IN YEARS LAST BIRTHDAY) 84 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (COUNTRY) (STATE OR FOREIGN) Connecticut	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's Co. MD		
10 CITY OR TOWN OF DEATH Adelphi	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Presidential Woods N.H.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Factory Worker		12b KIND OF BUSINESS OR INDUSTRY Royal Type-writers
13a STATE Maryland		13b COUNTY Prince Geo.	13c CITY OR TOWN New Carrollton	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Joseph Bitter		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Augusta Kraus			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. None		17 INFORMANT ADDRESS 6619 Adrian St. New Carrollton	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of Caecum.</u> Maryland 20784 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Pulmonary Metastases.</u> DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Cerebrovascular disease.</u>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 FOR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22 I certify that (1) this hospital attended the deceased from <u>May</u> 19 <u>87</u> to <u>October</u> 19 <u>87</u> that (2) we last saw the deceased alive on <u>September</u> 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (3) we (did, did not) view the body after death.					
22b SIGNATURE <u>Peter S Birk, MD</u>		DEGREE		22c DATE SIGNED 10/10/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) PETER S BIRK, MD		22e ADDRESS 10829 Georgia Ave, Wheaton, Md - 20902			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 10-14-87	23c NAME OF CEMETERY OR CREMATORY Mt. St. Benedict Cem.		23d LOCATION CITY OR TOWN COUNTY STATE Bloomfield Conn.	
24 FUNERAL DIRECTOR NAME Rendon/Hale Lanham Funeral Home		24b DATE REC'D. BY REGISTRAR OCT 15 1987		24c REGISTRAR'S SIGNATURE <u>John Rendon-Rodriguez</u>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove callow papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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OCT 19 1961

070497 NOV -287

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

30253

1 DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a DATE OF DEATH MONTH DAY YEAR		2b HOUR	
Inez Virginia Chapman				10 22 87		7:55A M	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)	
Female		Black		Mar. 20, 1916		71 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
Virginia		USA				Prince George MD	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Tocoma Park		Washington Adventist Hospital		Switch Bo. Oper.		BANK	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b STATE		13c COUNTY		13d CITY OR TOWN	
Maryland		Pr. George		Forestville		13e INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13f STREET ADDRESS / ZIP CODE			
Luther B. Banks		Mary E. Brown		7200 Donell Place, Apt. C-1 20747			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS			
NO		110-01-5145		Mr. Herbert W. R. Banks, Upper Marlboro, MD			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Sepsis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>							
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Lactopneumia</u> <u>1 wk</u>							
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Melanotic Carcinoma</u> <u>2 months</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 2, OR PART 3)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (1) this hospital attended the deceased from <u>22 Oct 87</u> to <u>22 Oct 87</u> that (2) we last observed alive on <u>22 Oct 87</u> and that (3) my opinion death occurred on the date and hour and from the causes stated							
23a SIGNATURE		DEGREE		23b DATE SIGNED			
Thomas A. Bensinger MD				10/23/87			
23c PHYSICIAN'S NAME (TYPE OR PRINT)		23d ADDRESS					
Thomas A. Bensinger MD		7525 Greenway Cir Drive Greenbelt MD 20910					
23e BURIAL CREMATION REMOVAL (SPECIFY)		23f DATE OF BURIAL CREMATION REMOVAL		23g NAME OF CEMETERY OR CREMATORY		23h LOCATION CITY OR TOWN COUNTY STATE	
Burial		Oct. 26, 1987		Bethel Bapt. Ch. Cem.		Amissville, Fauquier, VA	
24 FUNERAL DIRECTOR NAME		24b DATE REC'D BY REGISTRAR		24c REGISTRAR'S SIGNATURE			
JOYNES FUNERAL HOME, INC.		OCT 30 1987		Davidson-Randall			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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070146 OCT 29 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

30254

1 DECEASED NAME (TYPE OR PRINT) Mary Amelia CHESELDINE			2a DATE OF DEATH MONTH DAY YEAR Oct. 25, 1987			2b HOUR 1:58 A M	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR July 19, 1903		6 AGE (IN YEARS LAST BIRTHDAY) 84 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
10 CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY Home	
13a STATE MD.			13b COUNTY P. George's		13c CITY OR TOWN Suitland		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST Bernard E. Mattingly			15. MOTHER'S MAIDEN NAME MIDDLE LAST Cliffie Cryer				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO. 578-54-2525		17 INFORMANT Son ADDRESS 6926 Halleck St. Dist. Heights, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>concurrent pulmonary failure</i> DUE TO, OR AS A CONSEQUENCE OF, (b) <i>chronic heart failure</i> Conditions, if any, which gave rise to immediate cause (c) <i>chronic kidney failure</i> underlying cause (d) <i>concurrent pulmonary failure</i> PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>senile dementia, atherosclerosis</i>							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a ASPECT YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART 1; OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (1) this hospital attended the deceased from <i>10/17</i> 19 <i>87</i> to <i>11/25</i> 19 <i>87</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (2) we (do) not (do) not view the body after death.							
22b SIGNATURE <i>W. Clarke Mattingly</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10/28/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10/28/87		23c NAME OF CEMETERY OR CREMATORY St. Joseph's Cem.		23d LOCATION CITY OR TOWN Morganza STM MD.	
24 FUNERAL DIRECTOR NAME W. Clarke Mattingly				ADDRESS Leonardtwn, MD.		25a DATE REC'D BY REGISTRAR OCT 28 1987	
				25b REGISTRAR'S SIGNATURE <i>[Signature]</i>			

IMPORTANT: If item 21 is checked on item 18, please notify the medical examiner must be notified of death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

0-83729-371-9 \$0.00

1 DECEASED NAME (TYPE OR PRINT)			2a DATE KNOWN OF DEATH			2b HOUR		
DANIEL BRUCE CHRISTOPHER			X MONTH DAY YEAR 10-3-87 19			M		
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE		7 IF UNDER 24 HRS		7c DATE PRONOUNCED DEAD	
male	white	July 28, 1968	19 YRS				10-3-87 19 8:45a	
7a BIRTHPLACE		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED		9 BALTIMORE CITY OR COUNTY OF DEATH		
Virginia		USA		WIDOWED		Prince George's County MD		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a USUAL OCCUPATION		12b KIND OF BUSINESS OR INDUSTRY
Cheverly		Prince Gerge's County Hospital				student		college
13a STATE			13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?		13e STREET ADDRESS	
Maryland			Prince Georgrs	Laurel	YES NO		16833 Melbourne Drive 20810	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME					
Nathan Christopher			Marjorie Drach					
16a WAS DECEASED EVER IN U.S. ARMED FORCES?			16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS			
no			578 72 6107		Nathan Christopher same as above			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY								
IMMEDIATE CAUSE (a) Multiple injuries								
DUE TO, OR AS A CONSEQUENCE OF								
DUE TO, OR AS A CONSEQUENCE OF								
DUE TO, OR AS A CONSEQUENCE OF								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?					20 AUTOPSY?
								YES X NO
21a EXTERNAL CAUSE WAS			21b TIME OF INJURY		21c HOW INJURY OCCURRED			
UNDERLYING X OR CONTRIBUTING CAUSE OF DEATH			3:05am 10-3-87 19 PM		driver of an auto/auto head-on collision			
21d INJURY OCCURRED			21e PLACE OF INJURY		21f LOCATION			
WHILE NOT WHITE X AT WORK AT WORK			hgwyl		Rt. 197, 1 1/2 mile N. Of Jericho Pk. Bowie, Md.			
22a I certify that I took charge of the remains described above, held on								
Autopsy X Inspection Inquiry and in my opinion								
death resulted from: Highest causes Accident X Suicide Homicide Undetermined manner								
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED		
Charles P. Kokes, M.D.			Assistant MEDICAL EXAMINER			10-3-87		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS					
			111 Penn Street					
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION	
Burial			October 6, 1987		Ivy Hill Cemetery		Laurel, Maryland	
24 FUNERAL DIRECTOR			25a DATE REC'D. BY REGISTRAR					
Donaldson Funeral Home, Laurel, Md			OCT 13 1987					
			25b REGISTRAR'S SIGNATURE					
			John D. Anderson					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN SPACES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND (21201) PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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2000 COTTON 2000

WAX-7740



168123 OCT-987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

30256

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR
THOMAS RANDOLPH CLAY						OCT. 4, 1987						M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE		BLACK		JAN. 22, 1898		89 YRS.			MONTHS		DAYS	
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
MD.		U.S.A.				P.G.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
LANHAM			DOCTORS HOSPITAL			Waterman						

13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS		
MD.			ST. MARY'S			PINEY POINT			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			RT. 249/20674		
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME								
UNKNOWN						UNKNOWN								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)						16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
NO						213-16-22634			ERMAN T. CLAY, SR.			WASHINGTON, D.C.		

18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>			20019		
DUE TO, OR AS A CONSEQUENCE OF					
(b) <u>Myocardial infarction</u>					
DUE TO, OR AS A CONSEQUENCE OF					
(c) <u>Post-op. subdural hematoma</u>					

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
<u>Subdural hematoma</u>					

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
9-30-87		Subdural hematoma		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION			
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from <u>9-28-87</u> 19 <u>87</u> , to <u>10-6-</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>10-2-</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.					
--	--	--	--	--	--

22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>George Matthews</u>		MD		10-6-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
GEORGE MATTHEWS		Box 628 - Waldorf MD 20601			

23a. BURIAL, CREMATION REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
BURIAL		10/10/87		ST. MARKS CEM.		CITY OR TOWN COUNTY STATE	
						VALLEY LEE, ST. MARY'S MD.	

24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS		OCT 8 1987		<u>Julia Davidson-Randall</u>	
W. CLARKE MATTINGLEY, LEONARDTOWN, MD.					

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL-ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers: Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

068652 OCT 15 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

30257

REG NO

1. DECEASED NAME (TYPE OR PRINT)			FIRST DALE			MIDDLE R.			LAST CLIFTON			2a. DATE KNOWN OF DEATH		3. MEDICAL 10		4. DAY 10		5. YEAR 1987		6. HOUR M									
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH May 22, 1956		6. AGE (IN YEARS) 31 YRS		7. IF UNDER 1 YR MONTHS: DAYS: HOURS: MIN:		8. IF UNDER 24 HRS MONTHS: DAYS: HOURS: MIN:		2c. DATE PRONOUNCED DEAD		MONTH 10		DAY 10		YEAR 1987		7d. HOUR 11:14 P.M.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD																				
10. CITY OR TOWN OF DEATH Eagle Harbor			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) canal - Patuxent River			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Welder			12b. KIND OF BUSINESS OR INDUSTRY Gebhardt Con																				
13a. STATE Maryland										13b. COUNTY P. G.		13c. CITY OR TOWN Clinton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 7900 Malcolm Rd. 20735													
14. FATHER'S NAME FIRST John					MIDDLE Clifton, Sr.					LAST Anna					15. MOTHER'S MAIDEN NAME FIRST Anna					MIDDLE Langley					LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No					16b. SOCIAL SECURITY NO. N/A					17. INFORMANT John Clifton, Sr.					ADDRESS Same as 13 A-E														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Drowning</u> Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause last (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF																				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?															20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b. TIME OF INJURY HOUR <u>4:30</u> P.M. MONTH <u>10</u> -DAY <u>10</u> -YEAR <u>1987</u>					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Subject drowned while swimming.																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) canal					21f. LOCATION Patuxent River					CITY OR TOWN Prince George's					STATE MD									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																													
ACTUAL SIGNATURE <i>Mario F. Golle, Jr.</i>										TITLE (SPECIFY) Assistant MEDICAL EXAMINER										DATE SIGNED 10-11-87									
EXAMINER'S NAME (TYPE OR PRINT) Mario F. Golle, Jr., M.D.										ADDRESS 111 Penn St., Balto., MD 21201																			
23a. BURIAL, CREMATION, REMOVAL Burial					23b. DATE 10/14/87					23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery					23d. LOCATION Suitland Prince George's Md														
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.										ADDRESS 6633 Old Alexander Ferry Rd Clinton, Md 20735					25a. DATE REC'D BY REGISTRAR OCT 14 1987					25b. REGISTRAR'S SIGNATURE <i>John Davidson-Lindale</i>									

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

07/84
25MDHMH 17
(VR A) 15 ME

09875 OCT 12 65

068159 OCT-9 87

Item 5, Film 6532 10-14-87 dw

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 0 2 5 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) KATHERINE Gertrude COFFREN			2a. DATE OF DEATH MONTH DAY YEAR 10 3 87			2b. HOUR 2:16pm				
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Dec. 7, 1987		6. AGE (IN YEARS (LAST BIRTHDAY)) 55		7. IF UNDER 1 YEAR MONTH DAY HOUR MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD				
10. CITY OR TOWN OF DEATH CLINTON MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Insurance Agent		12b. KIND OF BUSINESS OR INDUSTRY Insurance		
13a. STATE Maryland			13b. COUNTY P. G.		13c. CITY OR TOWN Clinton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5918 Woodland Lane 20735	
14. FATHER'S NAME FIRST MIDDLE LAST Ralph Leroy Goddard			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Barbara Virginia Padgett							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT Norman W. Coffren		ADDRESS Same as 13 A-E			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of the lungs</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a										
19a. DATE OF OPERATION N/A			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE NO WHILE AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>1 July</u> 19 <u>86</u> to <u>10/3</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>10/3</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>William J. Oetgen, M.D.</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/4/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William J. OETGEN, M.D.			22e. ADDRESS 3611 BRANCH Ave Temple Hills, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/07/87		23c. NAME OF CEMETERY OR CREMATORY Christ Episcopal Ch. Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Clinton Prince Georges Md.			
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.			25a. DATE REC'D. BY REGISTRAR OCT - 8 1987			25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall				
ADDRESS 1633 Old Alexander Ferry Rd Clinton, Md 20735										

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

066123 OCT-30



80% COTTON FIBER
40% WOOL



OCT 30 1966

067924 OCT 07

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

30257

FOR
1. STATE
REGISTRAR

2a. DATE OF DEATH 10-4-87			2b. HOUR 1 M	
3. SEX M			4. RACE Caucasian	
5. DATE OF BIRTH 11/06/05			6. AGE (IN YEARS LAST BIRTHDAY) 81	
7a. BIRTHPLACE Virginia			7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD	
10. CITY OR TOWN OF DEATH Clinton			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Md. Hospital Center	
12a. USUAL OCCUPATION Civil Service			12b. KIND OF BUSINESS OR INDUSTRY Hospital	
13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13b. STREET ADDRESS 4267 Mockingbird Ct., 20601	
14. FATHER'S NAME Frank Walker Coleman			15. MOTHER'S MAIDEN NAME Annie Gregory	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) Yes WW II			16b. SOCIAL SECURITY NO 220-18-7023	
17. INFORMANT Marian McGrew Coleman Waldorf, Maryland			ADDRESS 4267 Mockingbird Ct.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Emphysema</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
--	--	---

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Pleural effusion</u>			
19a. DATE OF OPERATION <u>10/7/87</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Pleural effusion</u>	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21b. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART 1 OR PART 2)	
21c. PLACE OF INJURY (STREET, STREET, FACTORY, OFFICE, HOME, ETC.)		21d. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from <u>10/7/87</u> to <u>10/7/87</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If two) I (we) did not view the body after death.			
22b. SIGNATURE <u>[Signature]</u>		22c. DATE SIGNED <u>10/7/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Kere Grace MD Clinton, MD</u>		22e. ADDRESS <u>[Address]</u>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/7/87		23c. NAME OF CEMETERY OR CREMATORY Coleman Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Buckingham Co. Va	
24. FUNERAL DIRECTOR (NAME) Dunkum Funeral Home, Box 24, Dillwyn, Va23936				25a. DATE REC'D BY REGISTRAR OCT 07 1987 <u>[Signature]</u>			

DIVISION OF VITAL RECORDS, 301 W. PEESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH: 16-50M 1-81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. These permits are issued by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "Home," item 18 may vary injury, or other cause of death, as indicated on the certificate.

005054 OCT-095

OCT 07 1987

070065 OCT 29 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3020

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELDRED HUNTER COMSTOCK			2a. DATE OF DEATH MONTH DAY YEAR October 23, 1987		2b. HOUR 12:50p _M
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Dec. 8, 1934	6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS	7. UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Arkansas	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD		
10. CITY OR TOWN OF DEATH Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AMI Doctors' Hosp. of Pr. Geo. Co.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineering Mgr.	12b. KIND OF BUSINESS OR INDUSTRY Electrical	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY Prince Geo.	13c. CITY OR TOWN Bowie	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3029 Winchester Lane/20715	
14. FATHER'S NAME FIRST MIDDLE LAST Eldred H. Comstock		15. MOTHER'S MAIDEN NAME MIDDLE LAST Hilda Barbour			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (GIVE YEAR OR DATES) 1957-1960	17. INFORMANT ADDRESS Marie S. Comstock, Same as # 13.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of the Esophagus</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>with widespread metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/22</u> , 19 <u>87</u> , to <u>10/23</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>10/23</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>R. Dakheel MD</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED Oct 23, 1987
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Ried Dakheel, M. D.		22e. ADDRESS Suite 121 14300 Gallant Fox Lane Bowie, MD 20715			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Oct. 27, 1987	23c. NAME OF CEMETERY OR CREMATORY Cheltenham Veterans		23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham Maryland	
24. FUNERAL DIRECTOR Beall Funeral Home		16000 Annapolis Rd. Bowie, Maryland 20715		25a. DATE REC'D. BY REGISTRAR OCT 28 1987	25b. REGISTRAR'S SIGNATURE <u>Robert R. Rouse</u>

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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05002-01-0001

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070540 NOV-3 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

30201

1- STATE REGISTRAR		FOR DECEASED NAME FIRST MIDDLE LAST <i>Milton Chester Gordon</i>		2a DATE KNOWN OF DEATH MONTH DAY YEAR <i>Oct 28 1987</i>		2b HOUR <i>5:00 PM</i>	
3 SEX <i>M</i>	4 RACE <i>W</i>	5 DATE OF BIRTH MONTH DAY YEAR <i>Aug 13 1953</i>	6 AGE (IN YEARS) YEARS MONTHS DAYS <i>34 YRS</i>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c DATE PRONOUNCED DEAD MONTH DAY YEAR <i>Oct 28 1987</i>	7d HOUR <i>5:00 PM</i>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD.</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges MD</i>	
10 CITY OR TOWN OF DEATH <i>Riverdale</i>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>5312 Kenilworth Ave</i>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE <i>MD</i>		13b COUNTY <i>Prince Georges</i>		13c CITY OR TOWN <i>Riverdale</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET ADDRESS <i>5312 Kenilworth Ave</i>		14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>YES</i>		16b SOCIAL SECURITY NO. <i>KOREAN</i>		17 INFORMANT ADDRESS <i>SUZANNE DAVIS, sister- Temple, 1049 E. ElFreda Rd. S. Arizona</i>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Sudden Myocardial Dis.</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <i>None</i>							
19a DATE OF OPERATION <i>None</i>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH P.M. 19		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>J. L. Rogers</i>		TITLE (SPECIFY) <i>M.D. Dep.</i>		MEDICAL EXAMINER		DATE SIGNED <i>Oct 28 1987</i>	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS					
23a BURIAL, CREMATION, REMOVAL <i>Removal</i>		23b DATE <i>10-29-87</i>		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE	
24 FUNERAL DIRECTOR NAME ADDRESS <i>State Anatomy Board Balto., Md.</i>				25a DATE REC'D BY REGISTRAR <i>NOV 02 1987</i>		25b REGISTRAR'S SIGNATURE <i>Julia D. Anderson</i>	

070240 101-381

070240 101-381

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page]

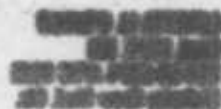
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove and deposit in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.							
DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH							
RAYMOND CONRAD JOSEPH COTE		OCT 22 1987 8:24 AM							
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)						
Male	Caucasian	Sept. 20, 1915	72						
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH						
Mass.	U.S.A.		Prince George's MD						
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b KIND OF BUSINESS OR INDUSTRY						
Camp Springs	Malcolm Grow Hospital AAFB	Fire Controlman	Govt.						
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b CITY OR TOWN	13c INSIDE CITY LIMITS?	13d STREET ADDRESS / ZIP CODE						
Maryland	P. G.	Upper Marlboro	9230 Goldenrod Lane 20772						
14 FATHER'S NAME	15 MOTHER'S MAIDEN NAME								
Peter	Viva	Stoddard							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b SOCIAL SECURITY NO	17 INFORMANT	ADDRESS						
Yes	WWII	Donna Cote	Same as 13 A-E						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) <u>ATHEROSCLEROTIC DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____									
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY?	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
		YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)							
21d INJURY OCCURRED	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE							
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>									
22 I certify that (1) this hospital attended the deceased from <u>16 OCT</u> 19 <u>87</u> to <u>22 OCT</u> 19 <u>87</u> that (1) was last saw the deceased alive on <u>22 OCT</u> 19 <u>87</u> and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (1) was (did) not view the body after death.									
23a SIGNATURE	DEGREE	23c DATE SIGNED							
Louette M. Breen	MD	22 OCT 87							
23b PHYSICIAN'S NAME	23d ADDRESS								
	MALCOLM GROW USAF MED CTR (MAC) ANDREWS AFB, WASHINGTON, D.C. 20331								
23a BURIAL, CREMATION, REMAINS	23b NAME OF CEMETERY OR CREMATORY	23c LOCATION	23d COUNTY STATE						
Cremation	10/23/87 Lee's Crematory	Clinton, Prince George's	MD.						
24 FUNERAL DIRECTOR	25a DATE REC'D. BY REGISTRAR	25b REGISTRAR'S SIGNATURE							
Lee Funeral Home, Inc. 6638 Old Alexnader Ferry Rd Clinton, Maryland 20735	OCT 28 1987	Anderson-Randall							

BP

10 CS 100 01305



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 0 2 6 3

FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MARGARET MIDDLE PAULINE LAST COTRUFO			2a DATE OF DEATH MONTH DAY YEAR OCT 03 87		2b HOUR 02:45am
3 SEX FEMALE	4 RACE WHITE	5 DATE OF BIRTH MONTH DAY YEAR OCT. 4, 1903		6 AGE (IN YEARS LAST BIRTHDAY) 83 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) SCOTLAND	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD	
10 CITY OR TOWN OF DEATH CLINTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MALCOLM GROW HOSPITAL (AFB)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b KIND OF BUSINESS OR INDUSTRY OWN HOME
13a STATE MD.		13b COUNTY CHARLES	13c CITY OR TOWN INDIAN HEAD	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 9 EVELYN LANE 20640
14 FATHER'S NAME FIRST ALEXANDER MIDDLE PERRY LAST		15 MOTHER'S MAIDEN NAME FIRST MARGARET MIDDLE DICK LAST			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b SOCIAL SECURITY NO 217-32-2858		17 INFORMANT ADDRESS MARGARET D. CHAMPAGNE SAME AS #13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIOPULMONARY FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) MYLEODYSPLASTIC SYNDROME DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21b, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (i) (this hospital) attended the deceased from 29 SEP 19 87 to 3 OCT 19 87 that (i) (we) lost saw the deceased alive on 3 OCT 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (i) (we) (did) (did not) view the body after death.					
22b SIGNATURE Loretta M O'Brien		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED 3 OCT 87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) LORETTA M O'BRIEN		22e ADDRESS MALCOLM GROW USAF MED CEN AAFB MD 20331			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b DATE 10-5-87	23c NAME OF CEMETERY OR CREMATORY TRINITY MEMORIAL GARDEN WALDORF CHARLES MD.		23d LOCATION CITY OR TOWN COUNTY STATE	
24 FUNERAL DIRECTOR NAME AREHART FUNERAL HOME, INC. LA PLATA, MD.		25a DATE REC'D. BY REGISTRAR OCT 07 1987		25b REGISTRAR'S SIGNATURE Davidson	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. These permits are required by law. Please advise the funeral director of this requirement with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

BP

069351 OCT 22 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RAYMOND JOSEPH COURCHAINE			2a DATE OF DEATH MONTH DAY YEAR OCT 18 87			2b HOUR 8:47 pm	
3 SEX Male		4 RACE Cauc.		5 DATE OF BIRTH MONTH DAY YEAR 4 7 16		6 AGE (IN YEARS LAST BIRTHDAY) 71 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George MD	
10 CITY OR TOWN OF DEATH Andrews AFB		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Malcolm Grow Medical Center				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	
						12b KIND OF BUSINESS OR INDUSTRY Army	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e STREET ADDRESS / ZIP CODE 104 Talbert Dr. 20745	
13a STATE Maryland		13b COUNTY Pr. George		13c CITY OR TOWN Forest Hgts.					
14 FATHER'S NAME FIRST MIDDLE LAST Joseph O. Courchaine				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Colburn					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATE) 1946-1960		17 INFORMANT Harold E. Courchaine		ADDRESS Rt 2 Box 111		N.H. Charlestown	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (this hospital) attended the deceased from 10 AUG 19 87 to 18 OCT 19 87 that (we) last saw the deceased alive on 18 OCT 87, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) did view the body after death							
22b SIGNATURE Cathy J Schoorens				DEGREE MD		22c DATE SIGNED 18 OCT 1987	
22d PHYSICIAN'S NAME CATHY J. SCHOORENS Capt. USAF, MC 010-30-0415 AFSC				22e ADDRESS MGMCA AAFB, MD 20331			

23a BURIAL, CREMATION, (SPECIFY) Burial		23b DATE 10/21/87		23c NAME OF CEMETERY OR CREMATORY Md. Veteran Cem.		23d LOCATION CITY OR TOWN COUNTY STATE Cheltenham Md.	
24 FUNERAL DIRECTOR NAME G.P. Kalas 6160 Oxon Hill Rd. Oxon Hill, Md.				25 DATE RECEIVED BY REGISTRAR OCT 21 1987			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove column 1 (page 3) and page 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene given to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Elizabeth Elizabeth Mc Connell Cress			2a DATE OF DEATH MONTH DAY YEAR 10-5 87		2b HOUR 5:30 AM
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR 03 16 1912		6 AGE (IN YEARS LAST BIRTHDAY) 75 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) California	7b CITIZEN OF WHAT COUNTRY? U. S. A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD	
10 CITY OR TOWN OF DEATH CLINTON	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b KIND OF BUSINESS OR INDUSTRY U.S. Gov't.
13a STATE Maryland		13b COUNTY Charles	13c CITY OR TOWN Port Tobacco	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Warren E. Mc Connell		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Vera Fife		13e STREET ADDRESS / ZIP CODE Route 1 Box 1317 20677	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) N/A		17 INFORMANT ADDRESS Harold A. Wennberg, Rockville, Md. 20850	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>RENAL FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>MENINGITIS</u>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>DIABETES, CONGESTIVE HEART FAILURE</u>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 2 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NO WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>9/25</u> 19 <u>87</u> to <u>10/5</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>10-5</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
21b SIGNATURE Michael Levine		DEGREE MD		22c DATE SIGNED	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Michael Levine		22e ADDRESS 7801 OLD BRANCH AVE CLINTON MD 20735			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE 10-06-87		23c NAME OF CEMETERY OR CREMATORY Lee Crematory	
23d LOCATION (CITY OR TOWN) Clinton		COUNTY P.G.		STATE Md.	
24 FUNERAL DIRECTOR (NAME) Arehart Funeral Home, Inc.		ADDRESS La Plata, Md.		25a DATE REC'D BY REGISTRAR OCT 8 1987	
				25b REGISTRAR'S SIGNATURE Julia Davidson-Randall	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Crocker
07A3881STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

30200

1- STATE REGISTRAR NOV-28-87		FOR DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
ALICE L. CROCKER							OCTOBER 25, 1987		03:00 P.	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 UNDER 1 YEAR		7 UNDER 24 HRS		
Female	Caucasian	Oct. 5th 1919		68		YRS		MONTHS		MIN
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Phil., Pa.	USA			PRINCE GEORGE'S COUNTY MD.		Laurel		GREATER LAUREL BELTSVILLE HOSPITAL		Store Mgr. Ret. Pet Center
13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET ADDRESS / ZIP CODE		14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		
MD.	P.G.	Seabrook	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	6914 Woodstream Ter. 20706		Willard J. Lozo		Dorothy Eidel		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b SOCIAL SECURITY NO	17 INFORMANT		2218 Musgrove Rd.		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
n/a	207-03-8932	Gloria Moyer Silver Spr., Md. 20904								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c HOW INJURY OCCURRED		21d INJURY OCCURRED		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION
		P.M. 19								
22a I certify that (I) (this hospital) attended the deceased from _____ 1987 to _____ 1987 that (I) (we) last saw the deceased alive on _____ 1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.										
22b SIGNATURE		DEGREE		ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED				
Martin D. Wultz						10/26/87				
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS								
Martin D. Wultz		7525 Greenway Cir Orum Greenbelt Maryland 20770.								
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION				
Cremation		10/29/87		Balto. Wash. Crematory		Laurel P.G. Maryland				
24 FUNERAL DIRECTOR		24b ADDRESS		25a DATE REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE				
Fleck Funeral Home, Inc. Laurel, Md. 20		7601 Sandy Spring Road		OCT 30 1987		Julia Dutton-Lindner				

070501 100-301

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) CATHERINE CUMMINGS				7a DATE OF DEATH MONTH DAY YEAR 10 29 87				7b HOUR 4 AM	
3 SEX F		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 10 1 97		6 AGE (IN YEARS LAST BIRTHDAY) 90 YRS		8 UNDER 1 YEAR MONTH DAY HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH P.G. MD			
10 CITY OR TOWN OF DEATH Lanham		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MAGNOLIA GARDENS				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b KIND OF BUSINESS OR INDUSTRY -	
13a STATE Md		13b COUNTY P.G.		13c CITY OR TOWN Lanham		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 4833 Vaughn Pl. 20706	
14 FATHER'S NAME FIRST MIDDLE LAST John ENGLE				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY WOLF					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO 219-41-494		17 INFORMANT ADDRESS					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio Pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (b) stating the underlying cause last (b) Stroke DUE TO, OR AS A CONSEQUENCE OF (c) Emphysema heart Failure									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (10) hypertension, organic Brain syndrome.									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				70a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		70b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN REM. (B) PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE P.G. MD					
22a I certify that (I) (this hospital) attended the deceased from 8-27 19 87 to 10-29 19 87 that (I) (we) last saw the deceased alive on 10-29 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) not view the body after death.									
22b SIGNATURE R. Cardy				DEGREE MD				22c DATE SIGNED 10/29/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) RAKESH ALOPA				22e ADDRESS 14300 Gallant Fox Ln, Bowie MD 20715					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10/31/87		23c NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Randallstown, Maryland			
24 FUNERAL DIRECTOR NAME Rendon/Hale Lanham Fun'l Home ADDRESS 9013 Annapolis Rd. Lanham, Md. 20706									

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be filed in the funeral director's office. The funeral director should be detected for use as the burial-transit permit. Then please remove carbon paper. Page 1 must be filed in the funeral director's office. Page 2 must be filed in the funeral director's office. Page 3 must be filed in the funeral director's office. Page 4 must be filed in the funeral director's office. Page 5 must be filed in the funeral director's office. Page 6 must be filed in the funeral director's office. Page 7 must be filed in the funeral director's office. Page 8 must be filed in the funeral director's office. Page 9 must be filed in the funeral director's office. Page 10 must be filed in the funeral director's office. Page 11 must be filed in the funeral director's office. Page 12 must be filed in the funeral director's office. Page 13 must be filed in the funeral director's office. Page 14 must be filed in the funeral director's office. Page 15 must be filed in the funeral director's office. Page 16 must be filed in the funeral director's office. Page 17 must be filed in the funeral director's office. Page 18 must be filed in the funeral director's office. Page 19 must be filed in the funeral director's office. Page 20 must be filed in the funeral director's office. Page 21 must be filed in the funeral director's office. Page 22 must be filed in the funeral director's office. Page 23 must be filed in the funeral director's office. Page 24 must be filed in the funeral director's office. Page 25 must be filed in the funeral director's office. Page 26 must be filed in the funeral director's office. Page 27 must be filed in the funeral director's office. Page 28 must be filed in the funeral director's office. Page 29 must be filed in the funeral director's office. Page 30 must be filed in the funeral director's office. Page 31 must be filed in the funeral director's office. Page 32 must be filed in the funeral director's office. Page 33 must be filed in the funeral director's office. Page 34 must be filed in the funeral director's office. Page 35 must be filed in the funeral director's office. Page 36 must be filed in the funeral director's office. Page 37 must be filed in the funeral director's office. Page 38 must be filed in the funeral director's office. Page 39 must be filed in the funeral director's office. Page 40 must be filed in the funeral director's office. Page 41 must be filed in the funeral director's office. Page 42 must be filed in the funeral director's office. Page 43 must be filed in the funeral director's office. Page 44 must be filed in the funeral director's office. Page 45 must be filed in the funeral director's office. Page 46 must be filed in the funeral director's office. Page 47 must be filed in the funeral director's office. Page 48 must be filed in the funeral director's office. Page 49 must be filed in the funeral director's office. Page 50 must be filed in the funeral director's office. Page 51 must be filed in the funeral director's office. Page 52 must be filed in the funeral director's office. Page 53 must be filed in the funeral director's office. Page 54 must be filed in the funeral director's office. Page 55 must be filed in the funeral director's office. Page 56 must be filed in the funeral director's office. Page 57 must be filed in the funeral director's office. Page 58 must be filed in the funeral director's office. Page 59 must be filed in the funeral director's office. Page 60 must be filed in the funeral director's office. Page 61 must be filed in the funeral director's office. Page 62 must be filed in the funeral director's office. Page 63 must be filed in the funeral director's office. Page 64 must be filed in the funeral director's office. Page 65 must be filed in the funeral director's office. Page 66 must be filed in the funeral director's office. Page 67 must be filed in the funeral director's office. Page 68 must be filed in the funeral director's office. Page 69 must be filed in the funeral director's office. Page 70 must be filed in the funeral director's office. Page 71 must be filed in the funeral director's office. Page 72 must be filed in the funeral director's office. Page 73 must be filed in the funeral director's office. Page 74 must be filed in the funeral director's office. Page 75 must be filed in the funeral director's office. Page 76 must be filed in the funeral director's office. Page 77 must be filed in the funeral director's office. Page 78 must be filed in the funeral director's office. Page 79 must be filed in the funeral director's office. Page 80 must be filed in the funeral director's office. Page 81 must be filed in the funeral director's office. 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10135 101-101

NOT FOR PUBLICATION
EXCEPT BY AUTHORITY
OF THE SECRETARY OF DEFENSE

10135 101-101

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1- STATE
REGISTRAR

REG NO

DECEASED NAME
(TYPE OR PRINT)

FIRST MIDDLE LAST

IRVIN

Sylvester CURTIS

2a DATE OF DEATH MONTH DAY YEAR 2b HOUR
10 13 87 11 45AM

3 SEX

MALE

4 RACE

BLACK

5 DATE OF BIRTH

MONTH DAY YEAR
11 22 08

6 AGE (IN YEARS, LAST BIRTHDAY)

78

YRS

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Virginia

7b CITIZEN OF WHAT COUNTRY?

USA

8 MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☒

9 BALTIMORE CITY OR COUNTY OF DEATH

PRINCE GEORGE'S

MD

10 CITY OR TOWN OF DEATH

CHEVERLY

11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

NURSING CARE FACILITY

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Chauffer

12b KIND OF BUSINESS OR INDUSTRY

Transportation

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE Virginia

13b COUNTY Fauquier

13c CITY OR TOWN Warrenton

13d INSIDE CITY LIMITS?

YES ☐ NO ☒

13e STREET ADDRESS / ZIP CODE

Rt. 1, Box 303

14 FATHER'S NAME

John E. Curtis

15 MOTHER'S MAIDEN NAME

Maria Brown

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

no

16b SOCIAL SECURITY NO

705-10-9392

17 INFORMANT

John E. Curtis

ADDRESS

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1: DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Cardiorespiratory Arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the
underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

Chronic Organic Brain Syndrome, History of Congestive Heart Failure

19a DATE OF OPERATION

N/A

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

N/A

20a AUTOPSY?

YES ☐ NO ☒

20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐

21a ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER)

21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)

N/A

21d INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a I certify that (1) (this hospital) attended the deceased from 9/30, 1987, to 10/13, 1987, that (1) (we) last saw the deceased alive on 10/13, 1987, and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did not view the body after death.

22b SIGNATURE

Don H. Yobionowitz

DEGREE

MD

ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c DATE SIGNED

10/14/87

22d PHYSICIAN'S NAME (TYPE OR PRINT)

Don H. Yobionowitz

22e ADDRESS

10300 Greenbelt Rd, #101, Jessbrook, Md. 20706

23a BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b DATE

10/19/87

23c NAME OF CEMETERY OR CREMATORY

Curtis Family Cemetery Warrenton Fauquier Va.

23d LOCATION

CITY OR TOWN

COUNTY

STATE

24 FUNERAL DIRECTOR

Moser Funeral Home, Inc. Warrenton, Virginia

25a DATE RECD BY REGISTRAR

JCT 23 1987

25b REGISTRAR'S SIGNATURE

[Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 4 (temp. or final papers, pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to final disposition, or removal of the body.)

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

068359

OCT 12 1987
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87

30269

REG NO

1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST WALTER Cawood DADE, Sr.			2a DATE OF DEATH MONTH DAY YEAR 10 06 87			2b HOUR 12:05P M		
3 SEX MALE			4 RACE WHITE			5 DATE OF BIRTH MONTH DAY YEAR 02 09 09			6 AGE (IN YEARS LAST BIRTHDAY) 78 YRS		
7a BIRTHPLACE (COUNTRY) Maryland			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD		
10 CITY OR TOWN OF DEATH CHEVERLY			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S HOSPITAL CENTER			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Driver			12b KIND OF BUSINESS OR INDUSTRY Bus Company		
13a STATE Maryland			13b COUNTY P.G.			13c CITY OR TOWN Brentwood			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST Roger L. Dade			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susie E. Ball			13e STREET ADDRESS / ZIP CODE 3700 Perry Street 20722					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 577-03-6773			17 INFORMANT Mamie V. Dade (Wife) Brentwood, Md. 20722					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>ENDSTAGE CONGESTIVE CARDIAC FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <u>9-7-1987</u> to <u>10-6-1987</u> that (I) (we) last saw the deceased alive on <u>10-6-1987</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <u>M. S. Nayar</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED		
22d PHYSICIAN'S NAME (TYPE OR PRINT) S. M. NAYAR, M.D.						22e ADDRESS 3717-38 th AVE BRENTWOOD, MD 20722					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 10/09/87			23c NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery			23d LOCATION (CITY OR TOWN) Brentwood P.G. Maryland		
24 FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781						25a DATE REC'D. BY REGISTRAR OCT 13 1987			25b REGISTRAR'S SIGNATURE <u>Lisa Davidson-Randall</u>		

BP

828330

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)		FIR Jimmy		MID L.		LAST Darden		2a DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR HOUR 10 4 19 87 M	
3 SEX MALE	4 RACE BLACK	5 DATE OF BIRTH MONTH DAY YEAR MAY 10, 1951	6 AGE IN YEARS (LAST BIRTHDAY) 36 YRS	IF UNDER 1 YR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	7c DATE PRONOUNCED DEAD MONTH DAY YEAR HOUR 10 4 19 87 5:38A M		7d HOUR	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD			
10 CITY OR TOWN OF DEATH Laurel		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel/Beltsville Hospital				12a USUAL OCCUPATION (TYPE OF WORK) FOR MOST OF WORKING LIFE MEATCUTTER		12b KIND OF BUSINESS OR INDUSTRY PRIVATE	
13a STATE MARYLAND		13b COUNTY P.G.		13c CITY OR TOWN LAUREL		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 9190 CHERRY LANE	
14 FATHER'S NAME FIRST MIDDLE LAST AYMAN		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LELIA SPENCE		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO n/a					
16b SOCIAL SECURITY NO 238-80-4253		17 INFORMANT LAUREL, MARYLAND CELANE DARDEN 9190 CHERRY LANE							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. } (b) <u>Coronary artery anomaly</u> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 2 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Mario F. Golle, Jr.		TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED 10/5/87			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 111 Penn St.		Balto.MD.					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE 10-10-87		23c NAME OF CEMETERY OR CREMATORY CHURCH CEMETERY		23d LOCATION CITY OR TOWN GOLDSBORO		STATE N.C.	
24 FUNERAL DIRECTOR NAME ADDRESS JOHNSON & JENKINS FH, INC. 716 KENNEDY STREET N.W. WASH. D.C.				25a DATE REC'D. BY REGISTRAR OCT - 8 1987		25b REGISTRAR'S SIGNATURE Julia Terrell			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PLACE OF ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

060132 001-301



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BP

DHMH-1650M1-B1
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

27 30271

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR A		
1a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
3 SEX Female			4 RACE Black			5 DATE OF BIRTH MONTH DAY YEAR Sept. 12, 1987		
6 AGE (IN YEARS LAST BIRTHDAY)			7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			9 BALTIMORE CITY OR COUNTY OF DEATH		
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
13a STATE			13b COUNTY			13c CITY OR TOWN		
14 FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		
17 INFORMANT ADDRESS			16b SOCIAL SECURITY NO			16c DATE OF DEATH		
18 CAUSE OF DEATH PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ASPIRINIA NEOMATORUM</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe PREMATURITY</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>			19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED		
20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		
21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE			22a I certify that (I) (this hospital) attended the deceased from <u>9/13 1987</u> to <u>9/13 1987</u> that (I) (we) last saw the deceased alive on <u>9/13 1987</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		
22b SIGNATURE <u>Joel Borchini M.D.</u>			22c DATE SIGNED 11/4/87			22d PHYSICIAN'S NAME (TYPE OR PRINT)		
22e ADDRESS Cheverly, MD. 20785 PGHC			23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE		
23c NAME OF CEMETERY OR CREMATORY			23d LOCATION CITY OR TOWN COUNTY STATE			24 FUNERAL DIRECTOR NAME ADDRESS		
25a DATE REC'D. BY REGISTRAR			25b REGISTRAR'S SIGNATURE			26 DATE OF DEATH		

NOV 09 1987

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60% COTTON LIVER

67968 OCT-87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Alfred (NMN) DAVIS			2a DATE OF DEATH MONTH DAY YEAR 10 3 87		2b HOUR 12:02 AM						
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR 10 25 09		6 AGE (IN YEARS LAST BIRTHDAY) YRS 77		7 UNDER 24 HRS MONTHS DAYS HOURS MIN 77			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) England		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD					
10 CITY OR TOWN OF DEATH Greenbelt		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greenbelt Nsg Center				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self-employed		12b KIND OF BUSINESS OR INDUSTRY Pharmacist			
13a STATE Maryland		13b COUNTY Pr. George's		13c CITY OR TOWN Bowie		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 12323 Manvel Lane 20715			
14 FATHER'S NAME FIRST MIDDLE LAST Harry Davis			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lizzie Reid			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			16b SOCIAL SECURITY NO 145-05-2228		
16c ADDRESS 12323 Manvel Lane			16d ADDRESS Bowie, Maryland			16e ADDRESS 20715			17 INFORMANT Patricia D. Pross		
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (b) Metastatic prostate carcinoma underlying cause last (c) 2 years											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from 9/30/87 to 10/3/87 that (I) (we) last saw the deceased alive on 10/3/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE David Granite MD			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED 10/3/87		
22d PHYSICIAN'S NAME (TYPE OR PRINT) David Granite, MD			22e ADDRESS 115 Centerway Greenbelt								
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b DATE OCT 3, 1987			23c NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria, Fairfax, Virginia			23d LOCATION CITY OR TOWN COUNTY STATE		
24 FUNERAL DIRECTOR NAME Beall Funeral Home			16000 Annapolis Road Bowie, MD 20715-3043			25a DATE REC'D. BY REGISTRAR OCT 7 1987			25b REGISTRAR'S SIGNATURE W. J. Anderson-Randall		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

BP

68719 OCT 15 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

7 30273

1 DECEASED NAME (TYPE OR PRINT) Cecilia Genevieve Dawson			2a DATE OF DEATH MONTH DAY YEAR October 7, 1987		2b HOUR 7:15p M						
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR May 16, 1908		6 AGE (IN YEARS LAST BIRTHDAY) 79 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		8 IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD					
10 CITY OR TOWN OF DEATH Riverdale		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Memorial Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY Own Home			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland 13b COUNTY Prince Geo. 13c CITY OR TOWN Hyattsville						13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 6811 Calverton Drive 20782			
14 FATHER'S NAME FIRST MIDDLE LAST Joseph Broadwick						15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Robertson					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) ----- 216-38-5929		17 INFORMANT ADDRESS Donald Dawson, Same as Line #13							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Intractable respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Bilateral extensive pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Advanced large cell Non-Hodgkin's lymphoma</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Congestive heart failure, Arteriosclerotic heart disease, Previous cerebral infar-</u>											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <input checked="" type="checkbox"/> rct YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from <u>9-28</u> 19 <u>87</u> to <u>10-7</u> 19 <u>87</u> that (I) (we) lost saw the deceased alive on <u>10-7</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.											
22b SIGNATURE <u>Shrinivas Udapi</u> M.D.						DEGREE <u>MD</u>		22c DATE SIGNED 10-8-87		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Shrinivas Udapi, M.D.						22e ADDRESS 6005 Landover Road, Cheverly, Md. 20785					
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE Oct. 10, 1987		23c NAME OF CEMETERY OR CREMATORY St. Michael's Cem.		23d LOCATION CITY OR TOWN COUNTY STATE Frostburg, Allegany, Md.					
23e FUNERAL DIRECTOR NAME FRANCIS GASCH'S SONS FUNERAL HOME, P.A. 4739 Baltimore Ave., Hyattsville, Maryland						23f DATE REC'D BY REGISTRAR (IN REGISTRAR'S SIGNATURE) OCT 14 1987 <u>John S. Burden</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the funeral home permit. The detachable carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to removal, cremation, or removal.

IMPORTANT: If item 21 is marked as (a), (b), or (c), it shows any injury, whether traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove certain papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ESTELL SUDIE Demont				2a. DATE OF DEATH MONTH DAY YEAR 10/13/87				2b. HOUR MIN 6:55	
3. SEX FEMALE		4. RACE CAU.		5. DATE OF BIRTH MONTH DAY YEAR May 30, 1901		6. AGE (IN YEARS (LAST BIRTHDAY)) 86		7. IF DEER YEAR MONTH DAY HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.			
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY DOMESTIC	
13a. STATE MD.		13b. COUNTY P.G.		13c. CITY OR TOWN CLINTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 12114 Windbrook Dr. 20735	
14. FATHER'S NAME FIRST MIDDLE LAST THOMAS JENKINS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JEANETTE C. SMITH		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO					
16b. SOCIAL SECURITY NO 214-74-3322		17. INFORMANT Aline C. Windsor, Clinton, Md. 20735							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Ischemic cardiomyopathy DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18b, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8/15/87 to 10/12/87 that (I) (we) last saw the deceased alive on 10/12/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John Patterson		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 10/13/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Patterson, M.D.		22e. ADDRESS 7501 Serrano Rd. #201A Clinton, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10-17-87		23c. NAME OF CEMETERY OR CREMATORY St. Marys Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Piscataway, P.G., Md.			
24. FUNERAL DIRECTOR HUNTT FUNERAL HOME, WALDORF, MD. 20601		25. DATE RECEIVED BY REGISTRAR OCT 16 1987 REGISTRAR'S SIGNATURE Julia Tison-Rudolph							

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 4 and 5 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Ora Mae Dessi			2a. DATE OF DEATH MONTH DAY YEAR 10 18 87			2b. HOUR 2:50P M			
3 SEX Female		4 RACE Cauc.		5 DATE OF BIRTH MONTH DAY YEAR 10 12 15		6 AGE (IN YEARS LAST BIRTHDAY) 72 YRS		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George MD			
10 CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital Center				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired		12b KIND OF BUSINESS OR INDUSTRY Food Service	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a STATE Maryland		13b COUNTY Pr. George		13c CITY OR TOWN Forest Heights		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 118 Seneca Dr. 20745	
14 FATHER'S NAME FIRST MIDDLE LAST Walter H. Michael				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mattie Burton					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-18-6797		17 INFORMANT ADDRESS Barbara Anne Hunt 7625 Glenville Ct. Springfield, Va.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of lung</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Chronic obstructive</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pulmonary disease</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <u>11-27</u> 19 <u>85</u> to <u>10-18</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>10-17</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <u>M. Taleghani</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <u>10-19-87</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) M. Far Taleghani, M.D.				22e ADDRESS 4467 Old Branch Ave. Temple Hills, Md.					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10/21/87		23c NAME OF CEMETERY OR CREMATORY Stevensville Cemetery		23d LOCATION (CITY OR TOWN) COUNTY STATE Stevensville Md.			
24 FUNERAL DIRECTOR G.P. Kalas 6160 Oxon Hill Rd. Oxon Hill, Md.						25a DATE REC'D. BY REGISTRAR OCT 21 1987			
25b REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>									

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <i>mabel</i> MABEL ESTELLE ANDERSON DIGGS		2a DATE OF DEATH MONTH DAY YEAR 10 9 1987		2b HOUR 8:30 M	
3 SEX F Female	4 RACE C Black	5 DATE OF BIRTH 12 22 1889		6 AGE (IN YEARS LAST BIRTHDAY) 97 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC	7b CITIZEN OF WHAT COUNTRY? United States	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD	
10 CITY OR TOWN OF DEATH Adelphi	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Presidential Woods Health		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired/Seamstress		12b KIND OF BUSINESS OR INDUSTRY
13a STATE Maryland		13b COUNTY Montgomery	13c CITY OR TOWN Silver Spring	13d INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
14 FATHER'S NAME Unknown		15 MOTHER'S MAIDEN NAME Lovenia Anderson		13e STREET ADDRESS / ZIP CODE Apt. 1211; (20903) 8830 Piney Branch Road,	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO 579-10-4739		17 INFORMANT 8830 Piney Branch Rd. S.S.Md. Irene M. Williams (foster daughter)	

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH -
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Coronary Heart Failure</u>		10 yrs
(c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

Chronic Organic Brain Syndrome

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (1) (this hospital) attended the deceased from <u>9/14</u> , 19 <u>87</u> , to <u>10/7</u> , 19 <u>87</u> , that (2) (we) last saw the deceased alive on <u>10/7</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death			
22b SIGNATURE <i>Dr. H. Yoblonowitz</i>	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED 10/9/87
22d PHYSICIAN'S NAME (TYPE OR PRINT) Dr. H. Yoblonowitz, MD		22e ADDRESS 10300 Greenbelt Rd, Teabrook, MD	

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b DATE 10/15/87	23c NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	23d LOCATION CITY OR TOWN COUNTY STATE Suitland, P.G.CO. Maryland
24 FUNERAL DIRECTOR NAME LATNEY's Funeral Home		25a DATE REC'D BY REGISTRAR OCT 21 1987	
3831 Georgia Ave. NW, Washington, DC 20011		25b REGISTRAR'S SIGNATURE <i>John Davidson</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

069590 OCT 23 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST <u>Juanita</u> MIDDLE <u>Wagner</u> LAST <u>Dixon</u>		2a DATE OF DEATH MONTH <u>10</u> DAY <u>16</u> YEAR <u>87</u>		2b HOUR <u>5:55</u> AM	
3 SEX <u>Female</u>		4 RACE <u>White</u>		5 DATE OF BIRTH MONTH <u>7</u> DAY <u>25</u> YEAR <u>97</u>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Kansas</u>		7b CITIZEN OF WHAT COUNTRY? <u>United States</u>		6 AGE (IN YEARS LAST BIRTHDAY) <u>90</u> YRS.	
10 CITY OR TOWN OF DEATH <u>Hyattsville</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Carroll Manor nursing home</u>		9 BALTIMORE CITY OR COUNTY OF DEATH <u>Prince George's County</u> MD	
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Research Assistant</u>		12b KIND OF BUSINESS OR INDUSTRY <u>University</u>			
13a STATE <u>MD</u>		13b. COUNTY <u>Prince George's</u>		13c. CITY OR TOWN <u>Washington, DC</u>	
14 FATHER'S NAME FIRST <u>John</u> MIDDLE <u>E.</u> LAST <u>Wagner</u>		15 MOTHER'S MAIDEN NAME FIRST <u>Mayme</u> MIDDLE <u>Dunn</u> LAST <u>Dunn</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>061-14-6258</u>		17 INFORMANT <u>John Dixon, Same as 13</u>	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiorespiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) <u>CEPD, Left Lower Pneumonia</u>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>11 A</u> 19 <u>87</u> to <u>10 P</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>10</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <u>R. G. BHOJRAJ</u>		DEGREE <u>MD</u>		22c DATE SIGNED <u>10-16-87</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>R. G. BHOJRAJ, M.D.</u>		22e ADDRESS <u>204 Gosman Ave T-1 Laurel, MD 20607</u>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		23b DATE <u>10-17-87</u>		23c NAME OF CEMETERY OR CREMATORY <u>Metropolitan Crematory</u>	
23d LOCATION CITY OR TOWN COUNTY STATE <u>Alexandria, Virginia</u>					
24 FUNERAL DIRECTOR NAME <u>Richard Rapp, Inc.</u>		P. O. Box 43352, Washington, DC 20010		25a DATE REC'D BY REGISTRAR <u>OCT 22 1987</u>	
				25b REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Paul Revere Dolvin, Jr.			2a DATE OF DEATH MONTH DAY YEAR October 27, 1987		2b HOUR 3:30a M
3 SEX Male	4 RACE Married (W)	5 DATE OF BIRTH MONTH DAY YEAR Dec. 7, 1912		6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN) Missouri	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD	
10 CITY OR TOWN OF DEATH Riverdale	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Memorial Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer		12b KIND OF BUSINESS OR INDUSTRY NASA
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE Maryland	13c COUNTY P.G.	13d CITY OR TOWN Hyattsville	13e INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST Paul Revere Dolvin, Sr.		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Adeline Clem			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes Army W.W.II		16b SOCIAL SECURITY NO. 497-09-6226		17 INFORMANT 5902 31st Avenue, #513 Virginia B. Dolvin (Wife)Hyattsville, Md. 20782	
18 CAUSE OF DEATH Enter only one cause per line for a, b, and c. PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio-Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT (IF UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21d INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, IF MARKED) 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 6-15 19 87 to 10-27 19 87 that (I) (we) last saw the deceased alive on 6-15 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.					
22b SIGNATURE A.O. Moshayed, M.D.				22c DATE SIGNED 10-27-87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) A.O. Moshayed, M.D.				22e ADDRESS 5632 Annapolis Rd. #7 Bladensburg, Md. 20710	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE 10/28/87		23c NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria Virginia	
23d LOCATION (CITY OR TOWN) Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781		23e DATE REC'D. BY REGISTRAR NOV 4 1987			
23f REGISTRAR'S SIGNATURE Julia Davidson-Rudman					

BP

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NOV 10 1951

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WFO



069350 OCT 22 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Kenneth E. Donaldson SR			2a. DATE OF DEATH MONTH DAY YEAR 10 19 87			2b. HOUR 11:06 PM			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR February 11, 1935		6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN 10 19 87	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES County MD			
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Meat Cutter-Ret.		12b. KIND OF BUSINESS OR INDUSTRY Meat	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Prince George		13c. CITY OR TOWN Temple Hills		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3408 - 28th Pkwy. 20748	
14. FATHER'S NAME FIRST MIDDLE LAST Earl R. Donaldson					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frieda J. Erb				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 578-48-6408		17. INFORMANT ADDRESS Richard Donaldson Lot 162 Lyons Creek Lothian, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) head & neck cancer DUE TO, OR AS A CONSEQUENCE OF (c) radiation APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1:0 OR PART 2:0)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from June 1, 1987 to Oct 19, 1987 that (1) (we) last saw the deceased alive on Oct 19, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE [Signature]					DEGREE		22c. DATE SIGNED 10/20/87		
22d. PHYSICIAN'S NAME DJ HAIDAK					22e. ADDRESS Clinton Md		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/22/87		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland			
24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home					ADDRESS 6160 Oxon Hill Rd. Oxon Hill, Md.		25a. DATE REC'D. BY REGISTRAR OCT 21 1987		
					25b. REGISTRAR'S SIGNATURE [Signature]				

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH 16 60M 7:84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE
WASHINGTON, D. C. 20535
OCT 35 1981

OCT 31 1981

068653 OCT 15 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

30280

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VIVIAN DRURY			2a. DATE OF DEATH MONTH DAY YEAR 10 11 87		2b. HOUR 7:37 PM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Oct. 30, 1891		6. AGE (IN YEARS LAST BIRTHDAY) 96	7. UNDER 1 YEAR MONTHS DAYS YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD	
10. CITY OR TOWN OF DEATH CLINTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Md Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Home
13a. STATE Maryland	13b. COUNTY P. G.	13c. CITY OR TOWN Ft. Washington	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 12021 Livingston Rd 20744	
14. FATHER'S NAME FIRST MIDDLE LAST Walter Samuel Viles		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Caro Weston			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE BRANCH OR DATES) NO	16b. SOCIAL SECURITY NO. 263-76-7852	17. INFORMANT George E. Lowe		ADDRESS 706 Kings Ln Ft. Wash., Md. 20744	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) pneumonia DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) age					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NEEDED MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
22a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> WHILE AT HOME <input type="checkbox"/>		22b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		22c. LOCATION CITY OR TOWN COUNTY STATE Clinton Md Prince George's	
23. I certify that (a) (this hospital) attended the deceased from 10-6 , 19 87 , to 10-11 , 19 87 , that (b) we last saw the deceased alive on Oct. 10 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (a) (we) (did) (did not) view the body after death					
24. SIGNATURE Irwin H. Ruback, M.D.		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
25. PHYSICIAN'S NAME (TYPE OR PRINT) Irwin H. Ruback M.D.		26. ADDRESS 10905 Ft. Wash. Rd Ft. Wash., Md. 20744			
27a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	27b. DATE 10/12/87	27c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		27d. LOCATION CITY OR TOWN COUNTY STATE Clinton, Md Prince George's	
28. FUNERAL DIRECTOR NAME ADDRESS Lee Funeral Home Inc. Old Alexander Ferry Rd Clinton, Md 20735		29. DATE REC'D. BY REGISTRAR OCT 14 1987		30. REGISTRAR'S SIGNATURE Jina Decker-Randall	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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000000011287

Caroline Kent Jones
Garrison

Oct 10 1877
Wm. Kent Jones

X

Wm. Kent Jones

068929 OCT 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 30281

1 DECEASED NAME (TYPE OR PRINT)			2a DATE OF DEATH			2b HOUR		
JAMES LITTLETON DRY			OCT 09 1987			2:25 PM		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE			7 IF UNDER 1 YEAR		
Male	Caucasian	Sept. 4, 1918	69 YRS					
7a BIRTHPLACE (COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH				
Virginia	USA			Prince George's MD				
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY		
Camp Springs	Malcolm Grow A.F. Med. Ctr.		Petty Officer-US Navy					
13a STATE			13b COUNTY			13c CITY OR TOWN		
No. Carolina			Cabarrus			Concord		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			16a WAS DECEASED EVER IN U.S. ARMED FORCES?		
D. V. Dry			Mary Allen Lefler			Yes		
16b SOCIAL SECURITY NO			17 INFORMANT			18 CAUSE OF DEATH		
244 09 2139			Tafille Dry			PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>DISSEMINATED INTRAVASCULAR COAGULATION</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>PERFORATED GASTRIC ULCER</u>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (1) this hospital attended the deceased from 08 OCT 1987 to 09 OCT 1987 that (2) last saw the deceased alive on 09 OCT 1987 and that in (my) opinion death occurred on the date and hour and from the causes stated above; (3) (did) (did not) see the body after death								
22b SIGNATURE						DEGREE		22c DATE SIGNED
[Signature]						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		9 Oct 87
22d PHYSICIAN'S NAME						22e NAME OF HOSPITAL OR CLINIC		
[Signature]						MALCOLM GROW USAF MED CTR (MAE) - ANDREWS AFB, WASHINGTON, D.C., 20331		
23a BURIAL, CREMATION, REMOVAL			23b DATE			23c NAME OF CEMETERY OR CREMATORY		
Burial			Oct. 14, 1987			West Concord Cemetery		
23d LOCATION			23e DATE REC'D BY REGISTRAR					
West Concord, NC.			OCT 16 1987					
24 FUNERAL DIRECTOR			25a DATE REC'D BY REGISTRAR					
Ives-Pearson F. H. Arlington, Va. 22201			OCT 16 1987					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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MEDICAL CERTIFICATION

DHMH 16 60M 7/84
(VRA 15, 4)

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OCT 19 07
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069062 OCT 20 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

30282
REG NO.

1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE KNOWN OF ESTI DEATH MATED			2b HOUR		
Mary BROWN Duff						10-11 19 87			M		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS)	IF UNDER 1 YR	IF UNDER 24 HRS	7c DATE PRONOUNCED DEAD			7d HOUR		
FEMALE	WHITE	NOV. 1, 1922	64 YRS	MONTH DAY YEAR	MONTH DAY HOURS MIN	10-12 19 87			11:39 A M		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH		
VIRGINIA			U.S.A.						Prince George's County MD		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY		
Lanham			Thomas Seabrook Park			RET.- SECRETARY			FED. GOVT.		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS			
Md.		P.G.C.		LANHAM		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		9401 WORRELL AVE. 20706			
14 FATHER'S NAME FIRST MIDDLE LAST						15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
CONWAY LEE CARTER						MARY GLADYS JETT					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS				RT. 2, BOX 137 CENTER CROSS, VA.	
NO				229-18-4223		NANCY C. SCHOOLS					

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Gunshot wound of head
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? HEAD ONLY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 10-11 19 87		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET, FACTORY, EARM, ETC.) park (in auto)		21f LOCATION STREET CITY OR TOWN COUNTY STATE Thomas Seabrook Park, Lanham, Prince George's County, MD	

22a I certify that I took charge of the remains described above held an Autopsy ☒ Inspection ☐ Inquiry ☐
death resulted from ☐ Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐
and in my opinion

ACTUAL SIGNATURE Charles P. Kokes TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER DATE SIGNED 10-13-87
EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D. ADDRESS 111 Penn Street, Balto., MD 21201

23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION CITY OR TOWN COUNTY STATE
CREMATION	10-14-1987	CHAMBERS CREMATORY	RIVERDALE, P.G.C., Md.
24 FUNERAL DIRECTOR NAME ADDRESS		25a DATE REC'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE	
W. W. CHAMBERS CO. RIVERDALE, Md. 20737		OCT 19 1987 <u>John F. Anderson, Registrar</u>	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 1000. TO OBTAIN PAGE 5 FOR YOUR FILES, TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGE 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 BP
25M
DHMH - 17
(VR A15 ME (5))

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UNITED STATES OF AMERICA

U.S.A.

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA



UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial/cremation/removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Dorothy Downey Dumas			2a DATE OF DEATH MONTH DAY YEAR October 14, 1987		2b HOUR 1:15AM
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR July 23, 1901		6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C.	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's Co. MD	
10 CITY OR TOWN OF DEATH Greenbelt	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greenbelt Nursing Home		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Western Union	12b KIND OF BUSINESS OR INDUSTRY Telegraph Operator	
13a STATE Maryland		13b COUNTY Prince Geo.	13c CITY OR TOWN Seabrook	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Charles Melvin Boggs		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown Hartell		13e STREET ADDRESS / ZIP CODE 7115 Forbes Blvd. 20801	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO 578-05-3066		17 INFORMANT ADDRESS Dorothy D. Garro Seabrook, Md. 20706	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>sepsis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>aspirin poisoning</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 6 day					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>aspirin overdose heart disease & cigarette factors death taken both</u>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>July 16</u> 19 <u>87</u> to <u>Oct 13</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>Oct 13</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) not view the body after death.					
22b SIGNATURE <u>Till Bergemann</u> DEGREE _____				22c DATE SIGNED 10-14-87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Till Bergemann M.D.				22e ADDRESS 115 Centerway Greenbelt Maryland	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10-16-87		23c NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	
23d LOCATION CITY OR TOWN Washington D.C.		23e COUNTY 20770		23f DATE REC'D BY REGISTRAR OCT 19 1987	
24 FUNERAL DIRECTOR NAME Rendon/Hale Lanham Funeral Home				25b REGISTRAR'S SIGNATURE <u>Frederick B. Jones</u>	
24 ADDRESS 9013 Annapolis Rd. Lanham, Md. 20706				25a REGISTRAR'S SIGNATURE <u>Frederick B. Jones</u>	

1. The first part of the report is a general description of the project. It includes the title, the objectives, the scope, and the organization of the report. The title is "The Effect of Temperature on the Rate of Reaction of Hydrogen Peroxide with Potassium Iodate". The objectives are to determine the effect of temperature on the rate of reaction and to determine the activation energy of the reaction. The scope is limited to the reaction of hydrogen peroxide with potassium iodate in acidic solution. The organization of the report is as follows: Introduction, Experimental, Results, Discussion, and Conclusion.

2. The second part of the report is a description of the experimental procedure. It includes the materials, the apparatus, and the method. The materials are hydrogen peroxide, potassium iodate, and sulfuric acid. The apparatus consists of a reaction flask, a thermometer, and a stopper. The method is as follows: A known volume of hydrogen peroxide is added to a known volume of potassium iodate in a reaction flask. The flask is then sealed with a stopper and the temperature is measured. The reaction is allowed to proceed for a known time and the volume of oxygen gas evolved is measured.

3. The third part of the report is a description of the results. It includes the data, the graphs, and the calculations. The data are as follows:

Temperature (°C)	Volume of Oxygen (ml)	Time (s)
20	10	100
30	15	100
40	25	100
50	40	100
60	60	100

The graphs are as follows:

The calculations are as follows:

The rate of reaction is calculated as the volume of oxygen evolved per unit time. The rate increases with temperature. The activation energy is calculated using the Arrhenius equation. The activation energy is found to be 50 kJ/mol.

4. The fourth part of the report is a discussion of the results. It includes the interpretation of the data, the comparison with theory, and the conclusion. The data show that the rate of reaction increases with temperature. This is in agreement with the theory that the rate of reaction increases with temperature. The activation energy is found to be 50 kJ/mol, which is in agreement with the literature value of 52 kJ/mol. The conclusion is that the rate of reaction of hydrogen peroxide with potassium iodate in acidic solution increases with temperature and the activation energy of the reaction is 50 kJ/mol.

068723 OCT 15 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3028
REG NO

1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a DATE KNOWN OF DEATH ESTI- MATED		MONTH		DAY		YEAR		7b HOUR									
Ran		dolph		Louis		Dunn		10-6		19		87				M									
3 SEX		4 RACE		5 DATE OF BIRTH MONTH		DAY		YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS		IF UNDER 24 HRS. DAYS		7c DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		7d HOUR	
Male		White		2-5-72				75		YRS.						10-6		19		87		8:28		M	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED WIDOWED		NEVER MARRIED DIVORCED		9 BALTIMORE CITY OR COUNTY OF DEATH																	
Virginia		U.S.A.						Prince George's County																MD	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY																			
Lanham		Doctor's Hospital		Lieutenant		Metro. Police																		Dept.	
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS																	
Maryland		P.G.		Riverdale				6305 67th Court																	
14 FATHER'S NAME FIRST		MIDDLE		LAST		15 MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST															
Francis		Louis		Dunn		Adelaide		Hurdaway																	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INEORANT		ADDRESS																			
No		216-46-7773		Ethel W. Dunn (Wife) Riverdale, Md.		20737																			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
		Sudden pulmonary Cardiovascular disease																							
		Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last		(b)		DUE TO, OR AS A CONSEQUENCE OF																			
				(c)																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY?																					
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY		STATE															
22a I certify that I took charge of the remains described above, held on		Autopsy <input type="checkbox"/>		Inspection <input checked="" type="checkbox"/>		Inquiry <input checked="" type="checkbox"/>		and in my opinion																	
death resulted from		Natural causes <input checked="" type="checkbox"/>		Accident <input type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE		TITLE (SPECIFY)		M.D.		MEDICAL EXAMINER		DATE SIGNED																	
Augusto P. Rodriguez		Deputy						10-6/87																	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS																							
Augusto P. Rodriguez, M.D.		5009 Rayburn Ct., Temple Hills, MD																							
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (CITY OR TOWN)		COUNTY		STATE															
Burial		10/09/87		Fort Lincoln Cemetery		Brentwood		P.G.		Maryland															
24 FUNERAL DIRECTOR (NAME AND ADDRESS)		25a DATE REC'D BY REGISTRAR		25b REG. NO. OF REGISTRAR																					
Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781		OCT 14 1987		J. P. Davidson																					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

07/84

BP

DHMH - 17
(VR A15 ME (5))

088330 OCT 12 84

OCT 14 1984

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO.

1 - FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) WILLIAM H. EASTERLING			2a DATE OF DEATH MONTH 10 DAY 11 YEAR 87			2b HOUR 2 45PM			
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH Feb. DAY 21 YEAR 1922		6 AGE (IN YEARS LAST BIRTHDAY) 65		7 IF UNDER 1 YEAR MONTHS YRS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY			
10 CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES HOSPITAL CENTER				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor		12b KIND OF BUSINESS OR INDUSTRY Retail Food	
13a STATE Maryland		13b COUNTY Prince Geo.		13c CITY OR TOWN Bowie		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 13008 Marquette Lane/20715	
14 FATHER'S NAME FIRST Dick MIDDLE M. LAST Easterling				15 MOTHER'S MAIDEN NAME FIRST Sadie MIDDLE Stubbs LAST					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) WW II		17 INFORMANT Ruth W. Easterling, Same as # 13.		ADDRESS			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Post operative atelectasis DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of the lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 WK 2 WK	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Chronic obstructive pulmonary disease									
19a DATE OF OPERATION 9/25/87		19b CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of the lung				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from 9/25 19 87 to 10/11 19 87 that (I) (we) last saw the deceased alive on 10/11 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (I) (did) (did not) view the body after death.									
22b SIGNATURE Robert B. Wagner, M.D.				DEGREE M.D.				22c DATE SIGNED Oct. 12, 1987	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Robert B. Wagner, M.D.				22e ADDRESS 50 W. Edmonston Dr. Rockville, Md. 20852					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE Oct. 12, 1987		23c NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria, Fairfax, Virginia		23d LOCATION CITY OR TOWN COUNTY STATE			
24 FUNERAL DIRECTOR NAME Beall Funeral Home 16000 Annapolis Rd. Bowie, Maryland 20715				25a DATE REC'D. BY REGISTRAR OCT 16 1987		25b REGISTRAR'S SIGNATURE Julia Swenson-Pudenz			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. There please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 show any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary ECCLESTON			2a. DATE OF DEATH MONTH DAY YEAR October 11, 1987		2b. HOUR 2:40 P M
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 03-09-1912		6. AGE (IN YEARS (LAST BIRTHDAY)) 75 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD	
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk	12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Prince Geo.	13c. CITY OR TOWN Riverdale	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST James Burtrum		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dora Ellen Greenwalt			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 577-44-4610		17. INFORMANT 14591 Route #86, Thompson, James F. Trueter, Ohio, 44086	
18. CAUSE OF DEATH (Enter only one cause pending for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Acute heart failure. DUE TO, OR AS A CONSEQUENCE OF: (c) Myocardial infarction, circumferential, severe APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs Under 1 hr.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Renal failure, severe. Impaired heart failure. Diabetes mellitus. Terminal Urinary					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from 4/14 19 70 to 10/11 19 87 that I (we) last saw the deceased alive on 10/11 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) we (I) did (did not) view the body after death.					
22b. SIGNATURE William Henry Wilkin		DEGREE MD		22c. DATE SIGNED 10/12/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William Henry Wilkin		22e. ADDRESS 5807 Annapolis Road Hanover, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-15-87	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, P.G., Maryland
24. FUNERAL DIRECTOR NAME FRANCIS GASCH, SONS FUNERAL HOME, P.A.				25a. DATE RECEIVED BY REGISTRAR OCT 19 1987	
4739 Baltimore Ave., Hyattsville, Maryland				REGISTRAR'S SIGNATURE Julia Benson-Randall	

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ARMY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16 60M 7/B4
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a DATE OF DEATH MONTH DAY YEAR		2b HOUR	
Janet Ruth ECKSTORM				October 1, 1987		1:10 A.M.	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 UNDER 1 YEAR IF UNDER 1 YEAR	
Female	Caucasian	02 - 14 - 1934		53		MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Massachusetts	U.S.A.			Prince George's		MD	
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY		
Lanham	Doctors' Hospital of Pr. Geo. Co.		Reg. Nurse		Greenbelt N.H.		
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b STATE	13c COUNTY	13d INSIDE CITY LIMITS?	13e STREET ADDRESS / ZIP CODE			
Maryland		Pr. George's Greenbelt	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	6 Greentree Place 20770			
14 FATHER'S NAME FIRST MIDDLE LAST	15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS
Joseph Edward Greaves	Josephine Barrett		No		n/a		Albert Eckstorm Same as #13
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio Respiratory Arrest</u>							
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Possible intracranial bleed -</u>							
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cancer with metastasis</u>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 5 (3) (PART 2))			
21d INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>9/30/87</u> 19 <u>87</u> to <u>10/1/87</u> 19 <u>87</u> that (I) (we) lost above, (I) (we) (did) (did not) view the body after death and that in my (our) opinion death occurred on the date and hour and from the causes stated							
22b SIGNATURE				DEGREE		22c DATE SIGNED	
Gita K. Shah MD						10/1/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS			
Gita K. Shah, MD.				14333 Laurel Bowie Rd Laurel MD			
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE	
Burial		10/05/87		Resurrection Cem.		Clinton, Prince George's Maryland	
23e DIRECTOR'S SIGNATURE				23f DATE REC'D BY REGISTRAR		23g REGISTRAR'S SIGNATURE	
Francis Gasch's Sons Funeral Home, P.A.				OCT 8 1987			
4739 Baltimore Avenue, Hyattsville, Md. 20781							

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070482 NOV-287

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elizabeth Barbara EGGERS			2a DATE OF DEATH MONTH DAY YEAR October 26, 1987		2b HOUR 11:20am	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR November 3, 1906		
6 AGE (IN YEARS LAST BIRTHDAY) 80 YRS		7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b CITIZEN OF WHAT COUNTRY? United States		
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD		10 CITY OR TOWN OF DEATH Lanham		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AMI Doctors' Hosp. of Pr. Geo. Co.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY Own Home		
13a STATE Florida		13b COUNTY Palm Beach		13c CITY OR TOWN Boynton Beach		
13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 185-C High Point Blvd / 33435		14 FATHER'S NAME FIRST MIDDLE LAST (Unavailable) Mihalko		
15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (Unavailable)		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO 130-20-8379		
17 INFORMANT ADDRESS Christine M. Keunen, Washington, DC 20015		18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE cardiorespiratory failure DUE TO, OR AS A CONSEQUENCE OF severe pulmonary congestion + congestive failure DUE TO, OR AS A CONSEQUENCE OF chronic obstructive lung disease + coronary disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		
21f LOCATION STREET CITY OR TOWN COUNTY STATE		22a I certify that (I) (this hospital) attended the deceased from Oct 26 1987 to Oct 26 1987 , that (I) (we) last saw the deceased alive on Oct 26 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
22b SIGNATURE James W. Harding M.D.		DEGREE M.D.		22c ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
22d PHYSICIAN'S NAME (TYPE OR PRINT) James W. Harding M.D.		22e ADDRESS 7525 Greenway Center Dr., Greenbelt, Md. 207		22f DATE SIGNED 10/26/87		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE 10-27-87		23c NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		
23d LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia		24 FUNERAL DIRECTOR NAME Richard Rapp, Inc. P. O. Box 43352, Washington, DC 20010				
25a DATE REC'D BY REGISTRAR OCT 30 1987		25b REGISTRAR'S SIGNATURE Julia Davidson-Randall				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 does not list any injury, or other traumatic event, the medical examiner must be notified in advance.

785-131 50405

OPTIONAL FORM NO. 10
MAY 1962 EDITION
GSA GEN. REG. NO. 27

Checklist of the
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the various types of

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) SARAH MARJORIE EMERY			2a DATE OF DEATH MONTH DAY YEAR OCTOBER 29, 1987		2b HOUR 5 ¹⁰ PM
3 SEX FEMALE	4 RACE CAUCASIAN	5 DATE OF BIRTH MONTH DAY YEAR APRIL 15, 1894		6 AGE (IN YEARS LAST BIRTHDAY) 93	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, DC	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD	
10 CITY OR TOWN OF DEATH HYATTSVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL MANOR NURSING HOME		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK	12b KIND OF BUSINESS OR INDUSTRY I.R.S.	
13a STATE MARYLAND		13b COUNTY PR GEORGES	13c CITY OR TOWN HYATTSVILLE	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 4922 LASALLE ROAD 20782
14 FATHER'S NAME FIRST MIDDLE LAST WILLIAM EMERY		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH QUIRK			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b SOCIAL SECURITY NO 220-44-4277	17 INFORMANT ATTORNEY ADDRESS RICHARD GALIHER 5 N. ADAMS STREET ROCKVILLE, MD 20850		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 PNEUMONIA					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from AUG 23 19 82 to OCT 29 19 87 that (I) (we) last saw the deceased alive on OCT 15 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Kevin G. Nealon, M.D.		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED	
22d PHYSICIAN'S NAME (TYPE OR PRINT) DR. KEVIN G. NEALON		22e ADDRESS 916 19TH STREET STE. 618 WASHINGTON, D.C.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b DATE NOV 2, 1987	23c NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY		23d LOCATION (CITY OR TOWN COUNTY STATE) WASHINGTON, D.C.	
24 FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901		25a REG. NO. 111117 25b REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

100-901 711190

100-901 711190

100 50 VOM

068885 OCT 19 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

30291

1 DECEASED NAME (TYPE OR PRINT)		2a DATE KNOWN OF DEATH		2b HOUR	
FIRST MIDDLE LAST Emily Bertha Entzian		MONTH DAY YEAR 10-10-87		M	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS)	IF UNDER 1 YR	
Female	White	MONTH DAY YEAR 6-4-99	88 YRS	MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?		8 MARRIED		9 BALTIMORE CITY OR COUNTY OF DEATH
Kansas	United States		WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Prince George's County, MD
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY
Mitchellville	18507 Central Avenue		Homemaker		Own Home
13a STATE		13b COUNTY	13c CITY OR TOWN	13d STREET ADDRESS	
Maryland		Prince Geo.	Mitchellville	18507 Central Avenue/20717	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST Adolf Thieme		FIRST MIDDLE LAST Mae Smidt			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT	
No		216-38-6330		1201 Cedar Lane Lydia E. O'Bannon Edgewater, MD 21037	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Repetitive Cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause last (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetic</u>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE	
22a I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion					
ACTUAL SIGNATURE <u>Augusto P. Rodriguez</u>		TITLE (SPECIFY) <u>Deputy</u>		DATE SIGNED <u>10-12-87</u>	
EXAMINER'S NAME (TYPE OR PRINT) <u>Augusto P. Rodriguez, M.D.</u>		ADDRESS <u>5009 Rayburn Ct, Temple Hills, MD</u>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b DATE <u>Oct. 14, 1987</u>		23c NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	
				23d LOCATION <u>Suitland, P.G., Maryland</u>	
24 FUNERAL DIRECTOR NAME <u>Beall Funeral Home</u>		ADDRESS <u>16000 Annapolis Rd. Bowie, Maryland 20715</u>		25a DATE RECD. BY REGISTRAR <u>OCT 16 1987</u>	
				25b REGISTRAR'S SIGNATURE <u>Julia Deaton-Rudner</u>	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07-84
25M

BP

DHMH - 17
(VR A15 ME (1))

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70736 NOV -4 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)			2a DATE KNOWN OF ESTI- DEATH MATED			2b HOUR		
David F Esmacher, Sr.			10-29 1987			10-29 1987		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS)	IF UNDER 1 YR	IF UNDER 24 HRS.	2c DATE PRONOUNCED DEAD		
Male	Caucasian	Aug. 14, 1923	64 YRS.			10-29 1987		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Michigan	U.S.A.				Prince George's MD			
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY			
Camp Springs	Andrews AFB Malcolm J. Esmacher, Jr.		Coordinator		State Dept. Fed. Govt.			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET ADDRESS		13f ZIP CODE		
Maryland	Prince George's	Suitland	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	1912 Lakewood St.		20746		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME					
Frederick Esmacher			Margaret Waldecker					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b SOCIAL SECURITY NO.			17 INFORMANT ADDRESS		
Yes WWII			368-20-6769			Frances G. Esmacher 1912 Lakewood St. Suitland, Md.		
18 CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last (b) <u>arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?		
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <u>Augusto P. Rodriguez</u>			TITLE (SPECIFY) Deputy			DATE SIGNED 10-30-87		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS					
Augusto P. Rodriguez, M.D.			5009 Rayburn Ct, Temple Hills, MD					
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE			23c NAME OF CEMETERY OR CREMATORY		
Burial			11/2/87			Cedar Hill Cemetery		
23d LOCATION CITY OR TOWN			23e COUNTY			23f STATE		
Suitland			P.G.			Maryland		
24 FUNERAL DIRECTOR NAME			ADDRESS			25a DATE REC'D. BY REGISTRAR		
George P. Kalas Funeral Home			6160 Oxon Hill Rd. Oxon Hill, Md.			25b REGISTRAR'S SIGNATURE		
						NOV 03 1987		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM 2M (OBTAIN PAGE 5 FOR YOUR FILES). TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07-84
25M

BP

DHMH - 17
(VR A15 ME (5))

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[Faint text at the bottom of the page, possibly a signature or footer.]

69427 OCT 23 87

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

30293

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Avery Clinton Eubanks		2a. DATE OF DEATH MONTH DAY YEAR 10 14 87		2b. HOUR 944 AM	
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR April 2, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN) Lafayette, Georgia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD	
10. CITY OR TOWN OF DEATH CLINTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Safety Inspector		12b. KIND OF BUSINESS OR INDUSTRY Railroad
13a. STATE Tenn.		13b. COUNTY Hamilton	13c. CITY OR TOWN Chattanooga	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Edward Eubanks		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Beatrice Strain			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WWI		17. SOCIAL SECURITY NO. 704-09-5526		18. STREET ADDRESS / ZIP CODE 3711 Provence St. 99999	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsis Shock</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last: <u>Chronic obstructive Pulmonary Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic obstructive Pulmonary Disease</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>ASHC - c. Antibiotics</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <u>8/28</u> 19 <u>87</u> to <u>10/14</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>10/13</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>R. M. ...</u>				22c. DATE SIGNED 10/14/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. M. ...				22e. ADDRESS 3520 ... rd 20748	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/19/87		23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans Cem.	
23d. LOCATION (CITY OR TOWN) COUNTY STATE Cheltenham Prince George's MD		24. FUNERAL DIRECTOR Lee Funeral Home, Inc. Old Alexander Ferry Rd Clinton, Md 20735			
25a. DATE REC'D. BY REGISTRAR OCT 21 1987				25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified of this.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the body tags. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

1688 725 534 06

068129 OCT-98

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CECIL EMMONS FARRAR					2a. DATE OF DEATH MONTH DAY YEAR October 4, 1987			2b. HOUR 9:00a M			
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR August 25, 1915		6 AGE (IN YEARS LAST BIRTHDAY) 72 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a BIRTHPLACE (COUNTRY) Maine		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD					
10 CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AMI Doctors' Hosp. of Pr. Geo. Co.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Limousine Driver		12b. KIND OF BUSINESS OR INDUSTRY Transportation					
13a STATE Maryland		13b COUNTY P.G.		13c CITY OR TOWN P.G.		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 6505 Greenfield Court 20706			
14 FATHER'S NAME FIRST MIDDLE LAST Cecil Calvin Farrar		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie McCobb		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No							
16b SOCIAL SECURITY NO. 004-03-4139		17 INFORMANT Lorene H. Farrar (Wife) Lanham, Maryland									
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>generalized peritonitis and pulmonary embolism</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Cystectomy for carcinoma of bladder and multiple old M.C.s</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE TIME BETWEEN ONSET AND DEATH <u>20706</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>ASHD Diabetes Mellitus</u>											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (1) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (1) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (b) (we) (did not) view the body after death.											
22b SIGNATURE <u>[Signature]</u>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED			
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>Abolghassem Hafez MD</u>		22e ADDRESS <u>AMI P.G. Doctors' Hosp. Lanham Md.</u>									
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10/07/87		23c NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland					
24 FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781		25a DATE REC'D. BY REGISTRAR OCT 8 1987									
25b REGISTRAR'S SIGNATURE											

068158 OCT-9 37

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 30295

1 - FOR
STATE
REGISTRAR

REG. NO.

DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

ETTA

LOUELLA

FASOLD

2a DATE OF DEATH

MONTH

DAY

YEAR

2b HOUR

10-8-87

0415 AM

3 SEX

Female

4 RACE

Caucasian

5 DATE OF BIRTH

1-5-1929

6 AGE (IN YEARS LAST BIRTHDAY)

58

IF UNDER 1 YEAR

IF UNDER 1 YEAR

7a BIRTHPLACE

(STATE OR FOREIGN COUNTRY)

West Virginia

7b CITIZEN OF WHAT COUNTRY?

USA

8 MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

PRINCE GEORGES CO MD

10 CITY OR TOWN OF DEATH

CLINTON

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

SO MARYLAND HOSP

12a USUAL OCCUPATION

Clerk

12b KIND OF BUSINESS OR INDUSTRY

Dental Lab

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

Maryland

13b COUNTY

Charles

13c CITY OR TOWN

Waldorf

13d INSIDE CITY LIMITS?

YES ☐ NO ☒

13e STREET ADDRESS / ZIP CODE

2230 Pinefield Road 20601

14 FATHER'S NAME

Bernard

MIDDLE

Daugherty

15 MOTHER'S MAIDEN NAME

Lois

MIDDLE

Jones

16a WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)

no

16b SOCIAL SECURITY NO

(IF YES, GIVE WAR OR DATES)

--

17 INFORMANT

232-38-5907

ADDRESS

John C. Fasold - same as # 13

18 CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

CARDIAC ARREST

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

HEMOLYTIC ANEMIA, CHRONIC POSITIVE

DUE TO, OR AS A CONSEQUENCE OF

(c)

ACUTE SEPSIS

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

DIABETES MELLITUS, INSULIN DEPENDENT

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

YES ☐ NO ☐

20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c HOW INJURY OCCURRED

(ENTER NATURE OF INJURY IN ITEM 18, PART 2, OR PART 3)

21d INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e PLACE OF INJURY

(AT HOME STREET FACTORY OFFICE FARM, ETC.)

21f LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a I certify that (1) (this hospital) attended the deceased from 10/6 19 87 to 10/8 19 87 that the deceased

saw the deceased alive on 10/8 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

above (1) (we) (did) (did not) view the body after death

22b SIGNATURE

DEGREE

22c DATE SIGNED

Richard McConaughy MD

ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

10-8-87

22d PHYSICIAN'S NAME (TYPE OR PRINT)

Richard McConaughy

22e ADDRESS

5618 ST BARNABAS RD HONOLULU

23a BURIAL, CREMATION, REMOVAL

Burial

23b DATE

10-13-87

23c NAME OF CEMETERY OR CREMATORY

Md. Veterans

23d LOCATION

Cheltenham Pr. Geo. MD.

24 FUNERAL DIRECTOR

Hunt Funeral Home

P. O. Box 156

Waldorf, Md. 20601

25a DATE REC'D BY REGISTRAR

OCT 09 1987

25b REGISTRAR'S SIGNATURE

Richard McConaughy

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

80571 OCT 1985

SHORT

80571 OCT 1985

070079 OCT 29 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

30298
REG NO

FOR 1- STATE REGISTRAR		FIRST		MIDDLE		LAST		2a DATE OF DEATH		KNOWN ESTI MATED		MONTH		DAY		YEAR		7b HOUR	
DECEASED NAME (TYPE OR PRINT)		Diane		E.		Feggans		2c DATE PRONOUNCED DEAD		10		22		19		87		4:30 PM	
3- SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS)		IF UNDER 1 YR		IF UNDER 24 HRS		7c BALTIMORE CITY OR COUNTY OF DEATH		Prince George's County		MD			
Female		Black		3 8 57		30 YRS.													
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9							
Wash., D.C.		USA																	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY													
Cheverly		Prince George's General Hospital		Legal Secretary		Unknown													
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS											
D. C.				Washington		YES XX NO		1242 Emerson Street, N.E.											
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME																	
Melvin T. Feggans		Elizabeth Wright																	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS													
No		578-80-5093		Mr. Melvin T. Feggans/father/same as 93															
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Abdominal trauma with complications</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause last.																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																			
19a DATE OF OPERATION																			
19b CONDITION FOR WHICH OPERATION WAS PERFORMED?																			
20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																			
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH																			
21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5 XX 10 18 19 87																			
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Pedestrian struck by motorcycle																			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK																			
21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.) road																			
21f LOCATION STREET CITY OR TOWN COUNTY STATE Kenilworth Ave & Riverdale Rd, Riverdale, P.G.CO MD																			
22a I certify that I took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
22b I certify that I took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE <u>Dennis F. Smyth</u> TITLE (SPECIFY) Assistant Medical Examiner																			
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. ADDRESS 111 Penn St. Balto.MD.																			
23a BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial																			
23b DATE 10-28-87																			
23c NAME OF CEMETERY OR CREMATORY Ft. Lincoln																			
23d LOCATION CITY OR TOWN COUNTY STATE Brentwood, Md.																			
24 FUNERAL DIRECTOR John T. Rhines Co., 3015 12th St. N.E., D.C. 20017																			
25a DATE REC'D BY REGISTRAR 10/27/87																			
25b REGISTRAR'S SIGNATURE <u>[Signature]</u>																			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXCLUDE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. ONE PAGE 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH PAGE 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, PAGE 4 AND 5 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

BP 1987
DHMH 17
(VR A15 ME (1))

070018 001300

2027 COTTON 2003

069907 OCT 28 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Willie Lee FILHIOL			2a DATE OF DEATH MONTH DAY YEAR October 22, 1987		2b HOUR 6:20p M
3 SEX MALE	4 RACE BLACK	5 DATE OF BIRTH MONTH DAY YEAR DEC 27 1947		6 AGE (IN YEARS LAST BIRTHDAY) 39	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN 7.5
7a BIRTHPLACE STATE OR FOREIGN COUNTRY LOUISIANA	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH P.A. MD	
10 CITY OR TOWN OF DEATH LANHAM	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DOCTORS HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MANAGER		12b KIND OF BUSINESS OR INDUSTRY V.R.N. INC.
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE M.D.			13b COUNTY P.G.	13c CITY OR TOWN LANDOVER	
14 FATHER'S NAME FIRST MIDDLE LAST JAMES FILHIOL			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AMY ELLIOTT		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b SOCIAL SECURITY NO 435-66-3114		17 INFORMANT ADDRESS SHERLEEN FILHIOL 7008 EAST LAMBAR STREET LANDOVER MARYLAND	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Malignant Small cell tumor of the liver					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 mo
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from Sept 29 19 87 to Oct 22 19 87 that (I) (we) last saw the deceased alive on 10-22 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Kai-Yin Yew		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED 10-22-87
22d PHYSICIAN'S NAME (TYPE OR PRINT) Kai-Yin Yew, MD		22e ADDRESS 8916 Woodyard Rd #201 Clinton MD 20735			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION	23b DATE 10-27-87	23c NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE SUITLAND RD P.G. M.D.	
24 FUNERAL DIRECTOR NAME ROLLINS FUNERAL HOME, INC.		25a DATE REC'D BY REGISTRAR OCT 27 1987		25b REGISTRAR'S SIGNATURE Julia Dandrea-Rodgers	
WASHINGTON, D.C. 20019					

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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070080 OCT 29 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO.

30298

1 DECEASED NAME (TYPE OR PRINT)			2a DATE KNOWN OF DEATH			2b HOUR		
Isiah Fitzgerald			10/20 19 87			4:13 P.		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS)	IF UNDER 1 YR	IF UNDER 24 HRS	2c DATE PRONOUNCED DEAD		
Male	Black	Oct. 21, 1894	92 YRS			10/20 19 87		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		
N. C.		USA				Prince George's County MD		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY
Hyattsville		630 Sheridan Street, #109				Retired		Unknown
13a STATE			13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS		
Maryland			Prince George's	Hyattsville		630 Sheridan Street, #109		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME					
Mack Fitzgerald			Unk.					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS			
No			239-18-7608		Mrs. Effie Fitzgerald/wife/same as 13e			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>chronic myocardial disease.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
None								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?	
None							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
					None			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED		
			M.D. Deputy			10/21/87		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS					
John S. Rogers, M.D.			1919 Seminary Road			Silver Spring, Montgomery County, MD		
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE		
Burial		10-24-87		Cedar Hill		Suitland, Md.		
74 FUNERAL DIRECTOR NAME				ADDRESS		75a DATE REC'D BY REGISTRAR 75b REGISTRAR'S SIGNATURE		
John T. Rhines Co, 3015 12th St. N.E., D.C.						OCT 27 1987		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 1 PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07-84
25M

BP

DHMH - 17
(VR A15 ME (5))

78 00/00

12/20/87

12/20/87

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12/20/87 12/20/87 12/20/87

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12/20/87 12/20/87 12/20/87

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12/20/87

12/20/87 12/20/87

12/20/87 12/20/87

12/20/87 12/20/87

070862 NOV 5 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

30299

1 DECEASED NAME (TYPE OR PRINT) Anne DIXIE			2a. DATE KNOWN OF DEATH MONTH DAY YEAR Oct 28 1987			2b. HEALTH OF DEATH M 100%		
3 SEX F	4 RACE W	5 DATE OF BIRTH MONTH DAY YEAR April 6 1913	6 AGE (IN YEARS) (LAST BIRTHDAY) 74 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR Oct 28 1987		7d. HEALTH OF DEATH M 100%
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD		
10 CITY OR TOWN OF DEATH Riversdale		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Belmont Manor Hosp				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Quality Control Safeway Coffee		12b KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a STATE MD		13b COUNTY Prince Georges		13c CITY OR TOWN Hyattsville		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e STREET ADDRESS 8515 60th Ave		14 FATHER'S NAME FIRST MIDDLE LAST Vinton Evington Payne		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mittie Elizabeth Bailey		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		
16b SOCIAL SECURITY NO. 577-05-1666		17 INFORMANT ADDRESS 8107 20th Ave, Adelphi, Maryland 20783						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 None								
19a DATE OF OPERATION None			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE OF DEATH UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE John S. Rogers			TITLE (SPECIFY) M.D.			MEDICAL EXAMINER John S. Rogers		
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers			ADDRESS 1919 Seminary Rd., Silver Spring, M					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 10-31-87		23c NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Brentwood, P.G., Maryland	
24a NAME OF FUNERAL HOME FRANCIS GASCH'S SONS FUNERAL HOME, P.A.			24b ADDRESS 4739 Baltimore Ave., Hyattsville, Maryland 20781			24c DATE REC'D. BY REGISTRAR NOV 4 1987		
24d REGISTRAR'S SIGNATURE Julia T. ...			24e REGISTRAR'S SIGNATURE					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORMS 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH-17
(VR A15 ME (5))



20% CO-110111

W/111111

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This page should be removed from the certificate within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified of course.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Patricia A FLYNN				2a. DATE OF DEATH MONTH DAY YEAR October 20, 1987		2b. HOUR P 10:40 M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 4 11 46		6. AGE (IN YEARS LAST BIRTHDAY) 41 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD	
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse		12b. KIND OF BUSINESS OR INDUSTRY Medicine	
13a. STATE Maryland				13b. COUNTY Anne Arundel		13c. CITY OR TOWN Edgewater	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas A. Lamprose				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elois (Unknown)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212449159		17. INFORMANT ADDRESS James T. Flynn same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) pneumothorax DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min 2 hrs							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) intracranial tumor - post-operative - meningioma							
19a. DATE OF OPERATION 10/16/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED meningioma		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (a) (this hospital) attended the deceased from 10/9 19 87 to 10/20 19 87 , that (b) (we) last saw the deceased alive on 10/20 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (we) did not know the body after death.							
22b. SIGNATURE ARTNUR LITAFSKY MD				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/21/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARTNUR LITAFSKY MD				22e. ADDRESS 7525 Greenway Center Dr. Greenbelt MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/23/87		23c. NAME OF CEMETERY OR CREMATORY Mayo Mem. UMC Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Edgewater A. Arundel Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Hardesty Funeral Home, Annapolis, Md.				25a. DATE REC'D. BY REGISTRAR 10/23/1987			

069901 OCT 27 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

30301

1- FOR
STATE
REGISTRAR

2- DECEASED NAME
(TYPE OR PRINT)

FIRST
MARY

MIDDLE

LAST

FORD

2a DATE KNOWN OF DEATH ☒ MONTH DAY YEAR 7b HOUR
ESTI. MATED ☐ Oct 10 19 87 M

3 SEX

Female

4 RACE

Black

5 DATE OF BIRTH

AUG 15 1922

6 AGE (IN YEARS)

65 YRS.

IF UNDER 1 YR

MONTHS DAYS

IF UNDER 24 HRS

HOURS MIN.

7c DATE

PRONOUNCED DEAD

MONTH DAY YEAR HOUR
Oct 10 19 87 M

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

MARYLAND

7b CITIZEN OF WHAT COUNTRY?

U.S.A.

8 MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Prince Georges MD

10 CITY OR TOWN OF DEATH

UPPER MARLBORO

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

6501 Osborne Road

12a USUAL OCCUPATION (TYPE OF WORK)

HOUSEWIFE

12b KIND OF BUSINESS OR INDUSTRY

NONE

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

M.D.

13b COUNTY

P.G.

13c CITY OR TOWN

UPPER MARLBORO

13d INSIDE CITY LIMITS?

YES ☒ NO ☐

13e STREET ADDRESS

6501 OSBORNE RD.

20772

14 FATHER'S NAME

JAMES

MIDDLE

SMITH

15 MOTHER'S MAIDEN NAME

MARY

MIDDLE

BARRY

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)

NO

16b SOCIAL SECURITY NO

218-20-2130

17 INFORMANT

SHIRLEY HAMILTON

ADDRESS

3411 LODGE PARK RD. S.E. WASHINGTON D.C.

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) lung cancer
DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the under
lying cause last.

(b) _____
DUE TO, OR AS A CONSEQUENCE OF

(c) _____

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I

Radiation Therapy, hemoptysis

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED?

20 AUTOPSY?

YES ☐ NO ☒

21a EXTERNAL CAUSE WAS

UNDERLYING ☐ OR
CONTRIBUTING ☐ CAUSE OF DEATH

21b TIME OF INJURY

HOUR A.M. MONTH DAY YEAR
P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)

21f LOCATION

CITY OR TOWN COUNTY STATE

22a I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL
SIGNATURE

Augusto P. Rodriguez

Deputy

M.D.

MEDICAL EXAMINER

DATE SIGNED

10-10-87

EXAMINER'S NAME
(TYPE OR PRINT)

Augusto P. Rodriguez, M.D.

ADDRESS

5009 Rayburn Ct, Temple Hills, MD

23a BURIAL, CREMATION, REMOVAL (SPECIFY)

BURIAL

23b DATE

10-16-87

23c NAME OF CEMETERY OR CREMATORY

HARMONY CEMETERY

23d LOCATION

LANDOVER P.G. MARYLAND

STATE

24. BURIAL DIRECTOR
NAME

ROLLINS FUNERAL HOME, INC.

4339 HUNT PLACE, N.E.

WASHINGTON, D.C. 20019

25a. DATE REC'D. BY REGISTRAR

OCT 26 1987

25b. REGISTRAR'S SIGNATURE

Julia Davidson-Rodriguez

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 1, PAGE 5, FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH 17
VR A15 ME (15)

000001 000001

20% COTTON FIBER

WILEY



WILEY & SONS
400 HUNTER ST.
BOSTON, MASS.

8712 OCT 15 87

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FLORENCE LLOYD FREDERICK			2a DATE OF DEATH MONTH DAY YEAR October 11, 1987			2b HOUR 2:30AM			
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR 03-02-1905		6 AGE (IN YEARS LAST BIRTHDAY) 82		7 BENDER YEAR BENDER MONTH BENDER DAY BENDER MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD			
10 CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AMI Doctors' Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress		12b KIND OF BUSINESS OR INDUSTRY Self employed			
13a STATE Maryland		13b COUNTY Prince Geo.		13c CITY OR TOWN Berwyn Hts.		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 8802 Edmonston, 20740	
14 FATHER'S NAME FIRST MIDDLE LAST Samuel E. Lloyd			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Luella Baublitz						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO 216-01-8671		17 INFORMANT 5616 Hamilton Manor Dr. Apt. #1 Mr. Kinzie K. Cole, Hyattsville, Md. 20782					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio-Pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Atherosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <u>Chronic Renal failure. Non A Non B Hepatitis. Carcinoma Colon</u>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN (a), (b), OR (c))					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <u>8-28-87</u> to <u>10-11-87</u> that (I) (we) last saw the deceased alive on <u>10-10-87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated									
22b SIGNATURE <u>Dr. Steven Pollack</u> M.D. M.R.C.P.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED 10-11-87	
23a PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Steven Pollack				22e ADDRESS 7525 Greenway Center Dr 313 Greenbelt, Md					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10-15-87		23c NAME OF CEMETERY OR CREMATORY Forest Baptist Ch. Cem. Hereford, Baltimore, Md.		23d LOCATION CITY OR TOWN COUNTY STATE			
24 FUNERAL HOME FRANCIS GASCH'S SONS FUNERAL HOME, P.A. 4739 Baltimore Ave., Hyattsville, Maryland									

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

OCT 14 1987

J. A. Davidson

8 7 1 2 OCT 12 81

10

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED

OCT 14 1981

068399 OCT 14 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR1 DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

LEAUNTINE

J.

FREEMAN

2a DATE KNOWN OF DEATH
ESTIMATED
MONTH DAY YEAR HOUR
☒ 10 10 19 87 M

3 SEX

4 RACE

5 DATE OF BIRTH

6 AGE (IN YEARS)

IF UNDER 1 YR

IF UNDER 24 HRS

2c DATE PRONOUNCED DEAD

2d HOUR

FEMALE

BLACK

AUGUST 28, 1972

15 YRS

MONTH DAY HOURS MIN

10 10 19 87

6:11 P M

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

7b CITIZEN OF WHAT COUNTRY?

8 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

WASHINGTON, D.C.

UNITED STATES

Prince George's County MD

10 CITY OR TOWN OF DEATH

11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

12b KIND OF BUSINESS OR INDUSTRY

Cheverly

Prince George's General Hosp.

STUDENT

SCHOOL

13a USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13b STATE

13c COUNTY

13d CITY OR TOWN

13e INSIDE CITY LIMITS?

13f STREET ADDRESS

MARYLAND

PRINCE GEORGE

FT. WASHINGTON

YES ☒ NO ☐

1300 PALMER ROAD 20744

14 FATHER'S NAME

15 MOTHER'S MAIDEN NAME

BRIAN

FREEMAN

JEWELL

SILVERS

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)

16b SOCIAL SECURITY NO.

17 INFORMANT

NO

NONE

JEWELL SILVERS - 2337 25TH ST SE D.C.

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

8/5/

IMMEDIATE CAUSE (a) Multiple injuries

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

(b) DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED?

20 AUTOPSY?

21a EXTERNAL CAUSE WAS

21b TIME OF INJURY

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH

21d INJURY OCCURRED

Passenger of auto/fixed object impact.

WHILE ☐ NOT WHILE ☒ AT WORK

21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f LOCATION

CITY OR TOWN

COUNTY

STATE

road

N/B Rt. 4 near Brooks Dr., Prince George's MD

22a I certify that I took charge of the remains described above, held on

Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion

death resulted from

Natural causes ☐Accident ☒Suicide ☐Homicide ☐Undetermined manner ☐

ACTUAL SIGNATURE

TITLE (SPECIFY)

Assistant MEDICAL EXAMINER

DATE SIGNED 10-11-87

EXAMINER'S NAME (TYPE OR PRINT)

Mario F. Golle, Jr., M.D.

ADDRESS 111 Penn St., Balto., MD 21201

23a BURIAL, CREMATION, REMOVAL (SPECIFY)

23b DATE

23c NAME OF CEMETERY OR CREMATORY

23d LOCATION

COUNTY

STATE

BURIAL

10-15-87

MARYLAND NATIONAL CEM

LAUREL

MARYLAND

24 FUNERAL DIRECTOR

ADDRESS

25a DATE REC'D BY REGISTRAR

25b REGISTRAR'S SIGNATURE

POPE FUNERAL HOME - 2617 PA AVE S.E.

OCT 13 1987

Julia Decker-Rubio

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM BW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07 84
25M

BP

DHMH - 17
(VR A15 ME (5))

N



Item 17, Form 6533 11-12-87 dw

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

070378

1. DECEASED NAME FIRST MIDDLE LAST Minnie (no middle name) GAGLIA			2a. DATE OF DEATH MONTH DAY YEAR October 25, 1987		2b. HOUR 8:00 P ^M		
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR March 18, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD	
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors Hospital Of Lanham		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY PR.GEO.		13c. CITY OR TOWN N.Carrollton		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
14. FATHER'S NAME FIRST MIDDLE LAST Louis Russo		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucia DiPiano		13e. STREET ADDRESS / ZIP CODE 8308 Oliver St. 20784			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 145-07-6830		17. INFORMANT Charles A. gagli Sr, same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Septicemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of Prostate Gland with metastases</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>8 days</u> <u>9 months</u>							
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION 10-21-87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Obstructive Jaundice		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN REMARKS - SEE PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 10-18-87 to 10-25-87 that if (we) last saw the deceased alive on 10-25-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did not) view the body after death.							
22b. SIGNATURE George S. Banning M.D.				DEGREE M.D.		22c. DATE SIGNED 10-26-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS 5806 Baltimore Ave. Hyattsville, MD 20781			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/29/87		23c. NAME OF CEMETERY OR CREMATORY Gate Of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Md.	
24. FUNERAL DIRECTOR NAME Rendon/Hale Lanham Fun'l Home				25a. DATE REC'D. BY REGISTRAR OCT 30 1987		25b. REGISTRAR'S SIGNATURE Julia Rendon-Hale	
9013 Annapolis Rd. Lanham, Md. 20706							

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

070370 NOV-58

OCT 30 1958

069476 OCT 23 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO.

1- FOR STATE REGISTRAR		2a DATE KNOWN OF DEATH		2b HOUR	
3 DECEASED NAME (TYPE OR PRINT)		4 FIRST		5 LAST	
Helen		S.		Geraghty	
6 SEX	7 RACE	8 DATE OF BIRTH	9 AGE (IN YEARS)	10 IF UNDER 1 YR	11 IF UNDER 24 HRS
Female	Caucasian	Oct. 9, 1898	89		
12a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	12b CITIZEN OF WHAT COUNTRY?		13 MARRIED		14 BALTIMORE CITY OR COUNTY OF DEATH
Maryland	U.S.A.		XX		Prince Georges
15 CITY OR TOWN OF DEATH	16 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		17 USUAL OCCUPATION (TYPE OF WORK)		18 KIND OF BUSINESS OR INDUSTRY
Clinton	13515 Livingston Road		Executive Sec.		Fed. Govt.
19 USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		20 STATE		21 COUNTY	
Maryland		Prince Georges		Clinton	
22 FATHER'S NAME		23 MOTHER'S MAIDEN NAME		24 STREET ADDRESS	
Patrick Geraghty		Mary McHugh		13515 Livingston Road	
25 WAS DECEASED EVER IN U.S. ARMED FORCES?		26 SOCIAL SECURITY NO.		27 INFORMANT ADDRESS	
No		578-32-8501		V. Arlene Thacker Same as 13 A-E	
28 CAUSE OF DEATH (Enter only one cause or line for (a), (b), and (c).)					
PART I DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE					
Intermittent coronary cardiovascular disease					
DUE TO, OR AS A CONSEQUENCE OF					
Length congestive heart failure					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1					
Urinary tract infection, Renal inflammatory disease, dyspnea					
29a DATE OF OPERATION		29b CONDITION FOR WHICH OPERATION WAS PERFORMED		29c AUTOPSY	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
30a EXTERNAL CAUSE WAS		30b TIME OF INJURY		30c HOW INJURY OCCURRED	
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		HOUR A.M. MONTH DAY YEAR		ENTER NATURE OF INJURY IN ITEM 18 PART 3 OR PART 2	
31a INJURY OCCURRED		31b PLACE OF INJURY		31c LOCATION	
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		STREET, FACTORY, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE	
32a I certify that I took charge of the remains described above, held on					
Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion					
death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
33a ACTUAL SIGNATURE		33b TITLE (SPECIFY)		33c DATE SIGNED	
Augusto P. Rodriguez		Deputy		10-16-87	
34a EXAMINER'S NAME (TYPE OR PRINT)		34b ADDRESS		34c COUNTY	
Augusto P. Rodriguez MD		5709 Rayburn Court, Ctr Spr Md		Charles Maryland	
35a BURIAL, CREMATION, REMOVAL (SPECIFY)		35b DATE		35c NAME OF CEMETERY OR CREMATORY	
Burial		10/19/87		Trinity Mem. Gardens	
36a FUNERAL DIRECTOR NAME		36b DATE REC'D BY REGISTRAR		36c REGISTRAR'S SIGNATURE	
Lee Funeral Home, Inc.		OCT 21 1987		John Davidson-Randall	
37a ADDRESS		37b CITY OR TOWN		37c COUNTY	
6633 Old Alexander Ferry Rd.		Clinton, Md.		Maryland	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL. TRY TO GET PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07 84
25M

BP

DHMH - 17
(VR A15 ME (5))

000000 8 9 4 0 0 0



000000 8 9 4 0 0 0

70903 NOV -5 67

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

30300

1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE KNOWN OF DEATH			MONTH DAY YEAR			7b HOUR			
JOYCE			M.			GIROUARD			10-28-87			M			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS)		IF UNDER 1 YR		IF UNDER 24 HRS		7c DATE PRONOUNCED DEAD		7d HOUR	
Female		White		February 14, 1964		23 YRS		MONTHS		DATE		10-28-87		11:29	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b CITIZEN OF WHAT COUNTRY?				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 BALTIMORE CITY OR COUNTY OF DEATH			
Minnesota				USA								Prince George's County MD			
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b KIND OF BUSINESS OR INDUSTRY			
Laurel				Greater Laurel Beltsville Hospital				Enlisted Active Duty				Army			
13a STATE				13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS					
Md.				Montgomery		Silver Spring		X <input type="checkbox"/> NO <input type="checkbox"/>		14031 Castle Blvd. Apt 104					
14 FATHER'S NAME						15 MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST						FIRST MIDDLE LAST									
Charles T. Melby						Claudia M. Kelgey									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)						16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS							
Yes						Active Duty		475-92-8437 Steven S. Girouard; 14031 Castle Blvd. #104 SS, Md.							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1 DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) Multiple stabwounds															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.															
(b)															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1															
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?								20 AUTOPSY?			
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY				21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)							
				9:40p 10-28-87				subject stabbed							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f LOCATION							
				apartment 104				14031 Castle Blvd. Silver Spring, Maryland							
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>															
22b TIME (SPECIFY)															
ACTUAL SIGNATURE <i>Dennis F. Smyth</i> Assistant MEDICAL EXAMINER DATE SIGNED 10-29-87															
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. ADDRESS 111 Penn Street															
23a BURIAL, CREMATION, REMOVAL (SPECIFY)				23b DATE		23c NAME OF CEMETERY OR CREMATORY				23d LOCATION					
Removal				11-1-87		Hillside F/H Chapel				Minneapolis Mn					
24 FUNERAL DIRECTOR NAME										25a DATE REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Marshall's Funeral Home										NOV 04 1987		<i>Julia Gordon-Rader</i>			
4217 9th St NW: Washington, D.C.															

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD, "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07-84
25M

BP

DHMH - 17
(VR A15 ME (5))

[Faint, illegible handwriting]

3 0 3 0 1

FOR
STATE
REGISTRAR

REG NO

1 DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a DATE KNOWN OF DEATH		ESTIMATED MONTH DAY YEAR		2b HOUR	
Mary K. Glorius				10-2		1987			
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS)	7a IF UNDER 1 YR	7b IF UNDER 24 HRS	2c DATE PRONOUNCED DEAD		2d HOUR	
Female	White	March 2, 1909	78 YRS.			10-2		8:48	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Tennessee		U.S.A.				Prince Georges			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY			
Cheverly		Prince Georges General Hospital		Homemaker		Own home			
13a STATE		13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS			
Maryland		P.G.	Colmar Manor			3601 43rd Avenue		20722	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS	
Dock Sampson		Rebecca Hammond		No		579-01-4242-B		Bernard W. Glorius (sa me as spouse)	
18 CAUSE OF DEATH (Enter only one cause of death for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Diabetic arteriosclerotic cardiovascular disease</u> (b) <u>diarrhea</u> (c) <u></u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u></u>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion									
ACTUAL SIGNATURE <u>Augusto P. Rodriguez</u>		TITLE (SPECIFY) <u>Deputy</u>		DATE SIGNED <u>10-3-87</u>					
EXAMINER'S NAME (TYPE OR PRINT) <u>Augusto P. Rodriguez, M.D.</u>		ADDRESS <u>5009 Rayburn Ct, Temple Hills, MD</u>							
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE			
Burial		Oct. 6, 87		Cedar Hill Cemetery		Suitland P.G. Maryland			
24 FUNERAL DIRECTOR		25a DATE REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE					
Francis Gasch's Sons		4739 Baltimore Avenue		Oct 8 1987					
		Hyattsville, Md. 20781							

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAPERS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 WESTHEON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07 84
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DHMH 17
(VR A15 ME (5))

000134 OCT-987

May K. Glavin

Forbes Canal Bridge



Chapman F. Brainerd

20% COL 100 00003

10-3-97

10-3-97

10-3-97

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

FOR
1- STATE
REGISTRAR

2a BASED NAME
(PRINT)

FIRST
BRUCE

MIDDLE
LEE

LAST
GOLDSMITH

2b DATE KNOWN ☒ OF
DEATH ESTI-
MATED ☐ 10-21-87

3 SEX

Male

4 RACE

Cauc.

5 DATE OF BIRTH

Aug 16 1966

6 AGE (IN YEARS)

21 YRS

IF UNDER 1 YR

MONTHS DAYS HOURS MIN

IF UNDER 24 HRS

7c DATE

10-21-87

7d HOUR

10:20a

7a BIRTHPLACE (STATE OR
FOREIGN COUNTRY)

Maryland

7b CITIZEN OF WHAT COUNTRY?

U.S.A.

8 MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Prince George's County

10 CITY OR TOWN OF DEATH

Cheverly

11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Prince George's County Hospital

12a USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)

Carpenter

12b KIND OF BUSINESS
OR INDUSTRY

Construction

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

Maryland

13b COUNTY

St. Mary's

13c CITY OR TOWN

Mechanicsville

13d INSIDE CITY LIMITS?

YES ☐ NO ☒

13e STREET ADDRESS

Mechanicsville-Chaptico Rd

14 FATHER'S NAME

James

FIRST

R.

MIDDLE

14 Goldsmith

Goldsmith

15 MOTHER'S MAIDEN NAME

J.

FIRST

Elizabeth

Mikell

20622

16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)

No

16b SOCIAL SECURITY NO.

220-88-1980

17 INFORMANT

Teresa R. Goldsmith

ADDRESS

P.O. Box 254

Charlotte Hall

Md. 20622

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Gunshot wound of head

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED?

20 AUTOPSY?

YES ☒ NO ☐

21a EXTERNAL CAUSE WAS

UNDERLYING ☒ OR

CONTRIBUTING ☐ CAUSE OF DEATH

21b TIME OF INJURY

229hrs. 10-19-87

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

self/inflicted

21d INJURY OCCURRED

WHILE ☐ NOT WHILE ☒

AT WORK ☐ AT WORK ☒

21e PLACE OF INJURY (AT HOME

STREET, FACTORY, FARM, ETC.)

livingroom

21f LOCATION

STREET

P.O. Box 269 Chaptico Rd. Mechanicsville, Md.

22a I certify that I took charge of the remains described above, held on

Autopsy ☒

Inspection ☐

Inquiry ☐

and in my opinion

death resulted from:

Natural causes ☐

Accident ☐

Suicide ☒

Homicide ☐

Undetermined manner ☐

ACTUAL
SIGNATURE

Margarita A. Korell, M.D.

TITLE (SPECIFY)

Assistant

M.D. MEDICAL EXAMINER

DATE 10-22-87

SIGNED

EXAMINER'S NAME
(TYPE OR PRINT)

Margarita A. Korell, M.D.

ADDRESS

111 Penn Street

23a BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b DATE

10/24/87

23c NAME OF CEMETERY OR CREMATORY

Trinity Mem Gardens

23d LOCATION
CITY OR TOWN

Waldorf, Charles, Md.

COUNTY STATE

24 FUNERAL DIRECTOR

NAME

Huntt Funeral Home

ADDRESS

P.O. Box 156

Waldorf, Md 20601

25a DATE REC'D BY REGISTRAR

OCT 26 1987

25b REGISTRAR'S SIGNATURE

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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(VR AT 15 ME (5))

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20X COTTON 4858

080050

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (PRINT) ELIZABETH L. GOODMAN			2a. DATE OF DEATH MONTH DAY YEAR 10 27 87		2b. HOUR 5 55 P.M.
3 SEX Female	4 RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR July 29, 1929		6 AGE (IN YEARS LAST BIRTHDAY) 58	IF UNDER 1 YEAR MONTH DAY HOUR IF UNDER 1 DAY HOUR MINUTE
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S CO. MD	
10. CITY OR TOWN OF DEATH Clinton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SO. MARYLAND HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 3a. STATE Maryland			3b. COUNTY Charles		
3c. CITY OR TOWN Waldorf			3d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Michael E. Rogers			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellen A. Edelen		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No N/A		16b. SOCIAL SECURITY NO. 577-36-1790		17. INFORMANT ADDRESS Patricia Frame Same as 13 A-E	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Lung Cancer		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 13 MONTHS
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		
DUE TO, OR AS A CONSEQUENCE OF (b) _____		
DUE TO, OR AS A CONSEQUENCE OF (c) _____		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18b. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <u>Sept 19 86</u> to <u>Oct 27 87</u> that (I) (we) last saw the deceased alive on <u>10/27 87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Harry J. Katten		22c. DATE SIGNED 10/28/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HARRY KATTEN		22e. ADDRESS 8926 WOODBURN RD Clinton MD	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10/30/87	23c. NAME OF CEMETERY OR CREMATORY Epiphany Epis. Ch. Cem	23d. LOCATION CITY OR TOWN COUNTY STATE Forestville Prince George's MD
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.		25a. DATE REC'D. BY REGISTRAR NOV 04 1987	25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall
16633 Old Alexander Ferry Rd Clinton, Md 20735			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

171048 121-387



069071 OCT 20 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. REMAIN PAGES 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

30310
REG. NO.

1- FOR STATE REGISTRAR		2a CEASED NAME FIRST MIDDLE LAST KAREN Jayne GOSHEN		2b DATE KNOWN OF DEATH MONTH DAY YEAR 10 13 87		2c DATE OF DEATH MONTH DAY YEAR 10 13 87		2d HOUR M P 7:40 P	
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR Aug 16 1961	6 AGE YEARS MONTHS DAYS 26 YRS	7a IF UNDER 1 YR. MONTHS DAYS HOURS MIN	7b IF UNDER 24 HRS. MONTHS DAYS HOURS MIN	7c DATE PRONOUNCED DEAD MONTH DAY YEAR 10 13 87			
7a BIRTHPLACE WASHINGTON DC		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD			
10 CITY OR TOWN OF DEATH Capitol Heights		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION 1400 Nova Ave.				12a USUAL OCCUPATION Clerical		12b KIND OF BUSINESS OR INDUSTRY U S Gov't	
13a STATE Maryland		13b COUNTY Prince George		13c CITY OR TOWN Capitol Hts		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 4109 Torque Street	
14 FATHER'S NAME FIRST MIDDLE LAST Aubrey G Goshen		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Doris Jean Fleming		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b SOCIAL SECURITY NO. 577-92-2971		17 INFORMANT Aubrey G Goshen	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Manual strangulation</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 10-13-1987		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Subject was strangled.					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) house		21f LOCATION STREET CITY OR TOWN COUNTY STATE 1400 Nova Ave., Capitol Heights, Prince George MD					
22a I certify that I took charge of the remains described above, held on death resulted from:		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		MD					
Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED 10-14-87			
ACTUAL SIGNATURE Mario F. Golle, Jr., M.D.		EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		111 Penn St., Balto., MD 21201			
23a BURIAL, CREMATION, REMOVAL (SPEL. IF 2)		23b DATE 17Aug1987		23c NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Clinton PG Md			
24 FUNERAL DIRECTOR NAME ADDRESS Robert E Wilhelm Funeral Home		25a DATE REC'D BY REGISTRAR OCT 19 1987		25b REGISTRAR'S SIGNATURE James Gordon-Randall					

U7-84
25M

BP

DHMH: 17
(VR A15 ME (5))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1. FOR
STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT) HOMER C GRAVES			2a. DATE OF DEATH MONTH DAY YEAR 10 9 87		2b. HOUR 9 AM
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR March 16, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 86	IF UNDER 1 YEAR MONTH DAY HOUR YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore	
10. CITY OR TOWN OF DEATH Clinton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) So Maryland Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) salesman		12b. KIND OF BUSINESS OR INDUSTRY insurance
13a. STATE Maryland	13b. COUNTY Pr. George's	13c. CITY OR TOWN Camp Springs	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 5904 Center Drive 20748	
14. FATHER'S NAME FIRST MIDDLE LAST Clinton Graves		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Plumber			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) n/a	17. INFORMANT (wife) Eva A. Graves		ADDRESS same as 13 a-e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Admission
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CONGESTIVE HEART FAILURE					10-4-87 Expired in
DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY ARTERY DISEASE					10-4-87 at 9 AM
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CHRONIC RENAL INSUFFICIENCY					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (b) (this hospital) attended the deceased from 10-4 19 87 to 10-9 19 87 that (b) (we) last saw the deceased alive on 10-9 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death.					
22b. SIGNATURE S. J. Juman		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 10-9-87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SATISH JUMANI		22e. ADDRESS 3926 WOODWARD RD - CLINTON MD			
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) burial	23b. DATE Oct. 12, 1987	23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Church Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Laurel Grove, St. Mary's MD	
24. FUNERAL DIRECTOR NAME ADDRESS Lee Funeral Home, Inc. Old Alexander Ferry, Clinton, MD 20735		25a. DATE REC'D. BY REGISTRAR OCT 14 1987		25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall	

BP

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CLARK

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069459 OCT 23 '87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) GERTRUDE FRANCES GRAY			2a DATE OF DEATH MONTH DAY YEAR OCTOBER 14, 1987		2b HOUR 7:55 p.m.
3 SEX F	4 RACE W	5. DATE OF BIRTH MONTH DAY YEAR 6 24 86		6 AGE (IN YEARS LAST BIRTHDAY) 101 YRS	7 UNDER 1 YEAR 8 UNDER 1 YEAR 9 UNDER 1 YEAR
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MISSOURI	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD	
10 CITY OR TOWN OF DEATH TEMPLE HILLS	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANDREWS AIR FORCE HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK 1 OR MOST OF WORKING LIFE) UNK.		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD.		13b. COUNTY P.G.	13c. CITY OR TOWN TEMPLE HILLS	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 5708 Janice Lane 20748
14 FATHER'S NAME FIRST MIDDLE LAST MICHAEL ACKERMAN			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CHRISTINA LOUISE FELSMAN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 332-22-0600		17 INFORMANT ADDRESS Nancy Parks - daughter - s/a	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>ATHEROSCLEROTIC DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>7 OCT</u> 19 <u>87</u> to <u>14 OCT</u> 19 <u>87</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>14 OCT</u> 19 <u>87</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.					
22b. SIGNATURE <i>Loretta M O'Brien</i>				22c. DATE SIGNED 14 OCT 87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LORETTA M. O'BRIEN, CPT, USAF, MC				22e. ADDRESS MALCOLM GROW USAF MED CEN AAFB, MD 20331	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 10-14-87		23c. NAME OF CEMETERY OR CREMATORY	
24 FUNERAL DIRECTOR NAME State Anatomy Board		ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR OCT 21 1987	
				25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "Other", show any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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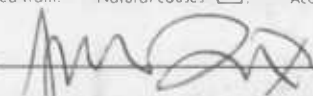
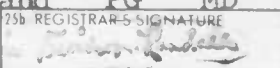
NOV 10 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

30313

REG NO

FOR STATE REGISTRAR
1- STATE REGISTRAR
2- MEDICAL EXAMINER
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100- MEDICAL EXAMINER

1- NAME (LAST, FIRST, MIDDLE) CARNIE A. GREEN		2a DATE KNOWN OF DEATH MONTH DAY YEAR 10 27 87		2b HOUR 8:10 P
3 SEX Male	4 RACE Black	5 DATE OF BIRTH MONTH DAY YEAR Aug 18 61	6 AGE (IN YEARS) YEARS MONTHS DAYS 26	7a DATE KNOWN OF DEATH MONTH DAY YEAR 10 27 87
7b BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7c CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		9b CITIZEN OF WHAT COUNTRY? U.S.A.		9c BALTIMORE CITY OR COUNTY OF DEATH Prince George's County
10 CITY OR TOWN OF DEATH District Heights		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2112 County Rd.		12a USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Teacher
13a STATE Maryland		13b COUNTY PG		13c CITY OR TOWN Forestville
14 FATHER'S NAME FIRST MIDDLE LAST King Green		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Juanita N. Freeman		16a USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Teacher
16b WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16c SOCIAL SECURITY NO. 579-80-0529		17 INFORMANT Washington, D.C. Juanita Green 215 17th St., NE
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cocaine Intoxication DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I				
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10 27 87		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Subject used drugs.
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) apartment		21f LOCATION STREET CITY OR TOWN COUNTY STATE 2112 County Rd., Dist. Hgts., Md.
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> .				
ACTUAL SIGNATURE 		TITLE (SPECIFY) Deputy Chief		DATE SIGNED 10-28-87
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.		ADDRESS 111 Penn St., Balto., MD 21201		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 11/3/87		23c NAME OF CEMETERY OR CREMATORY Lincoln Memorial Cem.
23d BURIAL PLACE (NAME) Budley & Sons Funeral Home		23e ADDRESS 3200 Rhode Island Ave, Mt. Rainier, MD		23f LOCATION CITY OR TOWN COUNTY STATE Suitland PG MD
24a DATE REC'D BY REGISTRAR NOV 9 1987		24b REGISTRAR'S SIGNATURE 		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07-84
25MADHMH - 17
(VR A15 ME (5))

68715 OCT 15 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Dorothy Ruth Grimley			2a DATE OF DEATH MONTH DAY YEAR 10 08 87		2b HOUR 1:30 A.M.
3 SEX Female	4 RACE Caucasian	5 DATE OF BIRTH MONTH DAY YEAR 12 19 17		6 AGE (IN YEARS LAST BIRTHDAY) 69 YRS	
7a BIRTHPLACE (COUNTY) Virginia	7b CITIZEN OF WHAT COUNTRY? United States	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD	
10 CITY OR TOWN OF DEATH Greenbelt	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 151 Westway Rd. T3		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY Own Home
13a STATE Maryland		13b COUNTY Prince Geo.	13c CITY OR TOWN Greenbelt	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Alfred Augustus Ball		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dora Ball Elkins			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 579-20-5110		17 INFORMANT 9504 48th Place James Grimley (son) College Park, MD 20740	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fallopian Tube Cancer</u> DUE TO OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last } (b) _____ DUE TO OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: <u>2 years 4 months</u>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (EXTERNAL NATURE OF INJURY ENTER IN PART 1 FOR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE	
22a I certify that (1) (this hospital) attended the deceased from <u>9/30</u> <u>87</u> to <u>10/8</u> <u>87</u> that (1) (we) last saw the deceased alive on <u>above</u> (1) (we) (did not) view the body after death					
22b SIGNATURE <u>Harvey K. 72-cv</u>		DEGREE <u>MD</u>		22c DATE SIGNED <u>10/9/87</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>HARVEY K. 72-cv</u>		22e ADDRESS <u>8926 Woodward Rd Clinton MD</u>			
23a BURIAL, CREMATION, REMOVAL (UNLESS BY)	23b DATE 10/12/87	23c NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Brentwood Prince Geo. MD	
24 FUNERAL DIRECTION Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave. Hyattsville, MD 20781		25a DATE REC'D BY REGISTRAR OCT 14 1987			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP _____

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NOV 14 1961

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068730 OCT 15 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 30315

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ethel E. Hamos			2a DATE OF DEATH MONTH DAY YEAR 10 09 87		2b HOUR 1817	
3 SEX F		4 RACE CAUC.		5 DATE OF BIRTH MONTH DAY YEAR 11 07 96		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		6 AGE (IN YEARS LAST BIRTHDAY) 90 YRS MONTH DAYS HOURS MIN		
10 CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hosp.		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George, MD		
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Administrator		12b KIND OF BUSINESS OR INDUSTRY U.S. Govt.				
13a STATE Maryland		13b COUNTY Mont.		13c CITY OR TOWN Silver Spring		
13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 12325 New Hampshire Ave. 20904				
14 FATHER'S NAME FIRST MIDDLE LAST Elmer E. Imlay		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Georgia Davis				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes WW 1		16b SOCIAL SECURITY NO. 579-62-5442		17 INFORMANT ADDRESS Marjorie E. Imlay (Niece) Bethesda, Md. 20816		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Small Bowel Intestine DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (a) Arteriosclerotic Heart Disease						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		70a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9 00 P.M. 19 87		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (1) this hospital attended the deceased from 9 00 19 87 to 9 00 19 87 that (2) I saw the deceased alive on 9 00 19 87 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (3) I (we) did not view the body after death						
22b SIGNATURE Michael Leibowitz, MD		DEGREE MD		22c DATE SIGNED 10 OCT 1987		
22d PHYSICIAN'S NAME (TYPE OR PRINT) Michael Leibowitz, MD		22e ADDRESS 11120 New Hampshire Ave SE, MS 28904				
23a BURIAL CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE Oct. 10, 1987		23c NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria, Virginia		
23d LOCATION CITY OR TOWN COUNTY STATE Washington DC Prince Georges MD		23e DATE REC'D BY REGISTRAR OCT 14 1987				
24 FUNERAL DIRECTOR NAME John F. DeVol		24a DATE REC'D BY REGISTRAR OCT 14 1987				
24b ADDRESS DeVol Funeral Home 2222 Wisc Ave, NW Wash, DC		24c REGISTRAR'S SIGNATURE John DeVol				

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please, remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "other", (18) how was body injured, or other traumatic event? The medical examiner must be notified at once.

Checked by MD **Michael Leibowitz** DeVol's 1930

068730 OCT 1961

Washington, D.C. U.S.A.

Thomas J. Ryan, Director, Federal Bureau of Investigation, U.S. Dept. of Justice

Mr. J. Edgar Hoover, Director, Federal Bureau of Investigation, U.S. Dept. of Justice

Mr. J. Edgar Hoover, Director, Federal Bureau of Investigation, U.S. Dept. of Justice

Mr. J. Edgar Hoover, Director, Federal Bureau of Investigation, U.S. Dept. of Justice

Anticipated first issue

Handwritten notes and signatures, including "M. J. Ryan" and "J. Edgar Hoover".

Oct 14 1961
FBI
U.S. Dept. of Justice

067928 OCT-87

OR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>DOROTHY C. HANBURY</u>			2a DATE OF DEATH MONTH DAY YEAR <u>10 5 87</u>		2b HOUR <u>9:58 AM</u>
3 SEX <u>Female</u>	4 RACE <u>White</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>12 6 1921</u>		6 AGE (IN YEARS LAST BIRTHDAY) <u>65</u> YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <u>0 0 0 0</u>
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Pennsylvania</u>	7b CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <u>PRINCE GEORGES</u> MD	
10 CITY OR TOWN OF DEATH <u>CLINTON</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>SOUTHERN MARYLAND Hospital Center</u>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Retired</u>		12b KIND OF BUSINESS OR INDUSTRY <u>Fed. Gov't.</u>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a STATE <u>Maryland</u>	13b COUNTY <u>Pr. Geo.</u>	13c CITY OR TOWN <u>Clinton</u>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS <u>7829 Denton Dr. 20735</u>	
14 FATHER'S NAME FIRST MIDDLE LAST <u>David White</u>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Elizabeth Nelson</u>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>167-18-5406</u>		17 INFORMANT ADDRESS <u>Harry D. Hanbury 7005 Kingston Dr. Temple Hills, Md. 20748</u>	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>IMMEDIATE</u>	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACUTE MYOCARDIAL INFARCTION</u>				4 DAYS	
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>CANCER OF LUNG</u>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>JULY 74</u> to <u>Oct 5</u> 19 <u>87</u> , that (I) (s) last saw the deceased alive on <u>10/4</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <u>Joseph P. Churn</u>		DEGREE <u>MD</u>		22c DATE SIGNED <u>10/5/87</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>Joseph P. Churn MD</u>		22e ADDRESS <u>931 PISCATAWAY RD CLINTON MD.</u>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b DATE <u>10-7-87</u>		23c NAME OF CEMETERY OR CREMATORY <u>Md. Veterans Cemetery</u>	
23d LOCATION CITY OR TOWN COUNTY STATE <u>Cheltenham P.G. Md.</u>					
24 FUNERAL DIRECTOR NAME ADDRESS <u>G.P. Kalas F.H. 6160 Oxon Hill Rd. Oxon Hill, Md.</u>				25a DATE REC'D. BY REGISTRAR <u>OCT 07 1987</u>	
				25b REGISTRAR'S SIGNATURE <u>Julia Anderson-Russell</u>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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NOTION



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 OR
 STATE
 REGISTRAR

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST MARY CORALIE HANUS			MONTH DAY YEAR October 9 1987			12:40P ^M		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)			7a. IF UNDER 1 YEAR		
Female	Caucasian	MONTH DAY YEAR 06 29 16	71 YRS			MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			
North Carolina	United States				Prince George's MD			
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Lanham	Doctors' Hospital of Pr. Geo. Co.			Driver			School Bus	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE			13b. CITY OR TOWN			13c. STREET ADDRESS / ZIP CODE		
Maryland			Prince Geo. Riverdale			6751 Riverdale Rd. 20737		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST Dean Montgomery			FIRST MIDDLE LAST Hattie Ford					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT		
No			579-09-4836A			Linda Burdsall(daughter) Same as #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROPRIATE INTERVALS BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral edema + infarct</u>								
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral infarct right side</u>								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebrovascular atherosclerosis</u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>atherosclerotic heart disease + chronic lung disease</u>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in item 18 Part 1 or Part 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE KARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22. I certify that (1) (this hospital) attended the deceased from <u>9-26-87</u> to <u>10-9-87</u> that (1) (we) last saw the deceased alive on <u>10-8-87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (2) (we) (did) (did not) view the body of the deceased.								
22b. SIGNATURE <u>James H. Harding</u> M.D.						22c. ADDRESS 7525 Greenway Ctr. Dr. #316 Greenbelt, Md. 20770		22d. DATE SIGNED 10/9/87
22a. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS					
James Harding, M.D.								
23a. BURIAL, CREMATION, REMOVAL (TYPE)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY	
Burial			10/12/87		Ft. Lincoln Cemetery		Brentwood Prince Geo. MD	
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave. Hyattsville, MD 20781						25a. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE OCT 14 1987 <u>John Burdsall</u>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, show any injury, or other traumatic event, the medical examiner should be notified at once.

BP

0-8-67-1-01 12 07

068244 OCT 9 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JUANITA A HARRISON		2a. DATE OF DEATH MONTH DAY YEAR 10/6/87		2b. HOUR 7:30 P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 9/27/04		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS. MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md	7b. CITIZEN OF WHAT COUNTRY? American	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD
10. CITY OR TOWN OF DEATH Clinton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Premier Manor Extended Care		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY N/A
13a. STATE md	13b. COUNTY P.A.	13c. CITY OR TOWN Clinton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS AND ZIP CODE 8600 N. Shepherd Dr. 21285-4288
14. FATHER'S NAME FIRST MIDDLE LAST Benjamin Wilkinson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ann L. Wible		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578-01-9983		17. INFORMANT Margaret E. Bubb ADDRESS 6704 Fulford St. Clinton, Maryland
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Aneurysm</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Arteriosclerotic Heart Disease</u>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 19a OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22. I certify that (I) (this hospital) attended the deceased from <u>9/25</u> 19 <u>87</u> to <u>10/6</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>10/5</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
21a. SIGNATURE <u>[Signature]</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/6/87
21b. PHYSICIAN'S NAME (TYPE OR PRINT) K S Z A MOSTAAN		22e. ADDRESS 4235 26 St. md 20746		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10/9/87	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION Washington, D. C. STATE
24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home		6160 Oxon Hill Rd. ADDRESS Oxon Hill, Md.		25a. DATE REC'D. BY REGISTRAR OCT 8 1987
25b. REGISTRAR'S SIGNATURE Julia Swanson-Randall				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

100-100 115831

68769 OCT 16 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) RICHARD L. HARRIS			2a DATE OF DEATH MONTH DAY YEAR 10-01-87			2b HOUR 6:10AM					
3 SEX Male		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR Nov. 19, 1921		6 AGE (IN YEARS LAST BIRTHDAY) 65		7b HOUR M			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD					
10 CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGE'S HOSPITAL CENTER		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b KIND OF BUSINESS OR INDUSTRY Construction					
13a STATE Md.			13b COUNTY P.G.		13c CITY OR TOWN Cedar Hgts.		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 5816 Jefferson Hgts. Dr. 20743		
14 FATHER'S NAME FIRST MIDDLE LAST John L. Harris			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pearl H. Jackson			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b SOCIAL SECURITY NO. 226-12-7013	
17 INFORMANT 5808 Jefferson Hgts. Dr.			18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Melastatic Pancreatic carcinoma			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 16 months					
DUE TO OR AS A CONSEQUENCE OF			DUE TO OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			DUE TO OR AS A CONSEQUENCE OF								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from 8/14/87 to 10/1/87 that (I) (we) last saw the deceased alive on 10/1/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death											
22b SIGNATURE V. P. Chandan			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10/1/87			
22d PHYSICIAN'S NAME (TYPE OR PRINT) V. Prem Chandan			22e ADDRESS 6001 Landover Rd. Cheverly Md 20785								
23a BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)			23b DATE 10/7/87		23c NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEM.		23d LOCATION CITY OR TOWN COUNTY STATE BLADENSBURG P.G. MD.				
24 FUNERAL DIRECTOR NAME H.S. WASHINGTON & SONS			ADDRESS 4925 BURROUGHS AVE. W.E.			25a DATE REC'D. BY REGISTRAR OCT 15 1987		REGISTRAR'S SIGNATURE Julia Davidson-Rodgers			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please return carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked as item 18, it indicates any injury, or other traumatic event, the medical examiner must be notified at once.)

BP

069682 OCT 26 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

30320

1. DECEASED NAME (TYPE OR PRINT) Lewis Louis		MIDDLE HARVEY		LAST HARVEY		2a. DATE OF DEATH MONTH DAY YEAR 10-17-87		2b. HOUR 7:50 P.M.	
3 SEX M		4 RACE B		5 DATE OF BIRTH MONTH DAY YEAR 8 3 07		6 AGE (IN YEARS LAST BIRTHDAY) 80		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN 0 0 0	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George MD			
10 CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) So. Md. Hospital Clinton		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Labor		12b. KIND OF BUSINESS OR INDUSTRY State Rd.			
13a STATE Maryland		13b COUNTY Calvert		13c CITY OR TOWN Sunderland		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE Gen. Del. 20689	
14 FATHER'S NAME FIRST MIDDLE LAST John Harvey		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Hoy		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no					
16b SOCIAL SECURITY NO. -		17 INFORMANT ADDRESS Josephine Ray P.O. Box 264 Huntingtown, Md							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ADENOCARCINOMA OF PROSTATE DUE TO, OR AS A CONSEQUENCE OF (c) METASTATIC.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from 9-30-87 19 to 10-17-87 19 that (I) (we) last saw the deceased alive on 10-17-87 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Krishan M. Mathur MD						DEGREE MD		22c DATE SIGNED 10/18/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) KRISHAN M. MATHUR				22e ADDRESS 17 Marshall Rd Waldorf Md. 20601					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Oct. 21, 87		23c NAME OF CEMETERY OR CREMATORY Mt. Hope Chr. Cem.		23d LOCATION CITY OR TOWN COUNTY STATE Sunderland Calvert Md			
24 FUNERAL DIRECTOR NAME Spencer E. Sewell				1451 Dares Beach Rd. ADDRESS Prince Frederick, Md 20678		25a DATE RECEIVED BY REGISTRAR OCT 23 1987			
25b REGISTRAR'S SIGNATURE									

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies, sign and seal and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director's office within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 3 0 3 2 1

1. FOR
STATE
REGISTRAR

REG. NO.

DECEASED NAME
(PRINT)

FIRST

MIDDLE

LAST

MARY

Alice

HAWKINS

2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR
10 31 87 4 A M

3 SEX

Female

4 RACE

Black

5 DATE OF BIRTH

MONTH DAY YEAR
06 28 1914

6 AGE (IN YEARS LAST BIRTHDAY)

73

IF UNDER 1 YEAR

MONTH DAY HOUR MIN.

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b CITIZEN OF WHAT COUNTRY?

USA

8 MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

PRINCE GEORGES COUNTY MD

10 CITY OR TOWN OF DEATH

CLINTON MD

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

SOUTHERN MARYLAND HOSPITAL

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

12b KIND OF BUSINESS OR INDUSTRY

13a STATE

Maryland

13b COUNTY

Prince Geo Brandywine

13c CITY OR TOWN

13d INSIDE CITY LIMITS? YES ☒ NO ☐

13e STREET ADDRESS / ZIP CODE 20613

13601 Old Indianhead Rd.

14 FATHER'S NAME

Charles Henry Dotson

15 MOTHER'S MAIDEN NAME

Mary Alice Skinner

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)

no

16b SOCIAL SECURITY NO.

577 44 5854

17 INFORMANT

George W. Hawkins SAA

18 CAUSE OF DEATH (Enter only one cause per line for a), b), and c)
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

CARDIAC ARREST

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

b)

CORONARY ARTERY DISEASE

DUE TO, OR AS A CONSEQUENCE OF

c)

ARTIC STENOSIS

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

YES ☐ NO ☐

20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐

21a ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d INJURY OCCURRED

21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f LOCATION

CITY OR TOWN

COUNTY

STATE

22a I certify that (1) this hospital attended the deceased from 10/20 19 87 to 10/31 19 87 that (2) we last saw the deceased physician above (1) and (2) did not see the body after death and that (3) my (our) opinion death occurred on the date and hour and from the causes stated

22b SIGNATURE

TERENCE BERTLE

DEGREE

MD

ATTENDING PHYSICIAN ☒

MEDICAL DIRECTOR ☐

STAFF PHYSICIAN ☐

22c DATE SIGNED

11/1/87

22d PHYSICIAN'S NAME (TYPE OR PRINT)

22e ADDRESS

7501 SURREATTS RD CLINTON MD 20735

23a BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b DATE

4 Nov 87

23c NAME OF CEMETERY OR CREMATORY

Christ UM Church

23d LOCATION

Baden, Prince Geo., MD

24 FUNERAL DIRECTOR

NAME

Martell Adams, Aquasco Md 20608

ADDRESS

25a DATE REC'D. BY REGISTRAR

NOV 06 1987

25b REGISTRAR'S SIGNATURE

John W. Anderson

021002 NOV-84

UNCLASSIFIED

SECRET

NOV 3 1984

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 0 3 2 2

REG. NO.

FOR
STATE
REGISTRAR

1- DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Rudean

Hawkins

2a. DATE KNOWN OF DEATH ☒ MONTH ☐ DAY ☐ YEAR ☐ HOUR
10-3 1987 M

3 SEX
Female

4 RACE
Black

5 DATE OF BIRTH
MONTH DAY YEAR
8-6-41

6 AGE (IN YEARS)
(LAST BIRTHDAY)
46 YRS.

IF UNDER 1 YR
MONTHS DAYS

IF UNDER 24 HRS
HOURS MIN

2c. DATE PRONOUNCED DEAD
10-3 1987 M

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
South Carolina

7b CITIZEN OF WHAT COUNTRY?
U.S.A.

8 MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH
Prince George's MD

10 CITY OR TOWN OF DEATH
Cheverly

11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Prince George's General Hospital

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Clerk

12b KIND OF BUSINESS OR INDUSTRY
D.C. Govt

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE
Maryland

13b COUNTY
P. George's

13c CITY OR TOWN
Hyattsville

13d INSIDE CITY LIMITS?
YES ☐ NO ☒

13e STREET ADDRESS
5018 54th Place

20781

14 FATHER'S NAME
FIRST MIDDLE LAST
Elliott

15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Rosa Durant

16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No

16b SOCIAL SECURITY NO.
250769351

17 INFORMANT
5018 54th Place
Carl Hawkins Hayattsville, Md. 20781

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Hypertensive cardiovascular disease

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED?

20 AUTOPSY?

YES ☒ NO ☐

21a EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d INJURY OCCURRED WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)

21f LOCATION
STREET CITY OR TOWN COUNTY STATE

22a I certify that I took charge of the remains described above, held on death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion

ACTUAL SIGNATURE

Augusto P. Rodriguez

M.D.

TITLE (SPECIFY)

Deputy MEDICAL EXAMINER

DATE SIGNED

10-3-87

EXAMINER'S NAME (TYPE OR PRINT)

Augusto P. Rodriguez, M.D.

ADDRESS

5009 Rayburn Ct, Temple Hills, MD

23a BURIAL, CREMATION, REMOVAL (SPECIFY)

23b DATE

23c NAME OF CEMETERY OR CREMATORY

23d LOCATION
CITY OR TOWN COUNTY STATE

Burial

10-10-87

Harmony Memorial Park

Landover

P.G.

Md.

24 FUNERAL DIRECTOR NAME

7474 Landover Road

25a DATE REC'D. BY REGISTRAR

25b REGISTRAR'S SIGNATURE

J. B. Jenkins

Landover, Md. 20785

OCT - 8 1987

Julia Gordon-Rodgers

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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5015 54th Place

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William L. Ferris

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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FOR per med exam
1- STATE REGISTRAR

REG NO

1 BASED NAME (OR PRINT)		FIRST		MIDDLE		LAST		2a DATE KNOWN OF DEATH		2b DATE OF DEATH		2c DATE OF DEATH		2d HOUR	
JONATHIN		J.		HENRY				10-16-87		10-16-87		1:24P			
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c DATE PRONOUNCED DEAD		7d HOUR			
Male	Black	Dec. 11, 1984		2 YRS.						10-16-87		1:24P			
7a BIRTHPLACE		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED		NEVER MARRIED		9 BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		USA		WIDOWED		DIVORCED		Prince George's County							
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL NURSING HOME, OR OTHER INSTITUTION		12a USUAL OCCUPATION		12b KIND OF BUSINESS OR INDUSTRY									
Bowie		Bowie Health Center		None											
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS							
MD		Pr. Geo.		Bowie		YES <input type="checkbox"/> NO <input type="checkbox"/>		13230 10th Street / 20715							
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME													
Ernest Henry		Brenda Price													
16a WAS DECEASED EVER IN U.S. ARMED FORCES?		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS									
No				Ernest Henry (father)		same as #13									

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Laryngeal edema</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <u>Laryngitis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a		

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 2 OR PART 3)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	

22a I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion	
ACTUAL SIGNATURE <u>Margie A. Korell</u>		TITLE (SPECIFY) Assistant MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.		ADDRESS 111 Penn Street	
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE	
Burial		10-19-87	
23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN	
Md Nat'l Memorial Pk.		Laurel, Pr. Geo, MD	

24 FUNERAL DIRECTOR NAME		ADDRESS		25a DATE REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
George R. Snowden		Rockville, MD		OCT 22 1987		<u>John Davidson</u>	

069424 OCT 23 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. ATTACH PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

080 37 OCT 23 64



W. J. P. 100-100000

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO.

1 DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a DATE KNOWN OF DEATH	ESTI MATED	MONTH	DAY	YEAR	2b HOUR
Marcia	Irene	Herber		10-31-	19	87			M

3 SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS) LAST BIRTHDAY	7a IF UNDER 1 YR. MONTHS DAYS HOURS MIN	7b IF UNDER 24 HRS.	2c DATE PRONOUNCED DEAD	MONTH DAY YEAR	2d HOUR
Female	Cau	Sept 9, 1962	25 YRS.			10-31-	19	87 3:45A

8 BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH
D.C.	U.S.A.		Prince George's County MD

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b KIND OF BUSINESS OR INDUSTRY
Upper Marlboro	Southbound Rt. 301	Office Manager	Rad. Serv.

13a USUAL RESIDENCE (IF IN HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS
Md.	Charles	Waldorf		Rt 5 Box 309-4 20601

14 FATHER'S NAME FIRST MIDDLE LAST	15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
William H. Miles	Marjorie Rule

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17 INFORMANT ADDRESS
No	215-84-1747	Rt 5 Box 309-4 William H. Miles, Waldorf, Md. 20601

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries Conditions, if any, which gave rise to immediate cause (a) stating the under lying cause last (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2:40AM 10-31-87	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Driver in auto-fixed object/ejected
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) cornfield	21f LOCATION STREET CITY OR TOWN COUNTY STATE Southbound Rt. 301, Upper Marlboro, Prince

22a I certify that I took charge of the remains described above, held on death resulted from	Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/>	George's Co., MD
---	--	--	------------------

ACTUAL SIGNATURE	TITLE (SPECIFY) M.D. Deputy chief	DATE SIGNED 10-31-87
---------------------	--------------------------------------	-------------------------

EXAMINER'S NAME (TYPE OR PRINT)	ADDRESS
Ann M. Dixon, M.D.	111 Penn St., Baltimore, MD 21201

23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION CITY OR TOWN COUNTY STATE
Burial	Nov. 3, 1987	Ft. Lincoln Cem.	Colmar Manor, P.G., Md.

24 FUNERAL DIRECTOR NAME ADDRESS	25a DATE REC'D. BY REGISTRAR	25b REGISTRAR'S SIGNATURE
Huntt Funeral Home Inc., Waldorf, Md.	NOV 03 1987	Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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25M

BP

DHMH - 17
(VR A15 ME (5))

104-VOL 10597

20% COTTON LBS

Wm. A. ...



Wm. A. ...

069842 OCT 27 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

30325

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Bessie Mae HERNDON			2a DATE OF DEATH MONTH DAY YEAR October 16, 1987		2b HOUR 1:20 A.M.
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR June 27, 1908		6 AGE (IN YEARS LAST BIRTHDAY) 79	YRS MONTHS DAYS IF UNDER 1 YEAR IF UNDER 24 HRS
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
10 CITY OR TOWN OF DEATH Lanham	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co.			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
13 USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland			13b COUNTY P.G.		
13c CITY OR TOWN Greenbelt			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST Arthur Barker			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nancy Carolyn Howell		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b SOCIAL SECURITY NO 226-30-4415		
17 INFORMANT (Son)			AD 4519 SR 33		
18 WILLIAM R. Herndon			Leesburg, Florida 32748		

18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiac arrest</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last	(b) <u>cardiogenic shock</u>	<u>1 day</u>
	(c) <u>myocardial infarction</u>	<u>1 day</u>
	PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)	

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>8/15</u> 19 <u>87</u> to <u>10/16</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>10/15</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.			
22b SIGNATURE <u>D. Granite MD</u>	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED <u>10/18/87</u>
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>D. Granite, MD</u>		22e ADDRESS <u>115 Centerway Greenbelt, Md.</u>	

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 10/20/87	23c NAME OF CEMETERY OR CREMATORY Resthaven Cemetery	23d LOCATION CITY OR TOWN COUNTY STATE Princeton Mercer West Virginia
23e NAME OF FUNERAL HOME Francis Gasch's Sons Funeral Home, P.A.		23f ADDRESS 4739 Baltimore Avenue Hyattsville, Md. 20781	
23g DATE RECEIVED BY REGISTRAR		23h REGISTRAR'S SIGNATURE	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201
Released to PMD by Medical ExaminerTO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

088042 OCT 25 84

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "October", "November", and "December" are faintly visible.]

068766 OCT 14 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

30320

1 DECEASED NAME (TYPE OR PRINT) Frederick Christopher Herzog, Jr.			2a DATE KNOWN OF DEATH MONTH DAY YEAR 10-12 1987			2b HOUR M		
3 SEX Male	4 RACE Caucasian	5 DATE OF BIRTH MONTH DAY YEAR June 12, 1922	6 AGE (IN YEARS) LAST BIRTHDAY 65 YRS.	7 IF UNDER 1 YR MONTHS DAYS HOURS MIN.	8 IF UNDER 24 HRS	2c DATE PRONOUNCED DEAD MONTH DAY YEAR 10-12 1987	2d HOUR M	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD		
10 CITY OR TOWN OF DEATH Ft. Washington		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS) 12416 Surrey Circle Drive				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Fed. Gov't. - Retired		
12b KIND OF BUSINESS OR INDUSTRY Fed. Gov't.		13a STATE Maryland		13b COUNTY Prince George		13c CITY OR TOWN Ft. Washington		
13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 12416 Surrey Circle		13f ZIP CODE 20744				
14 FATHER'S NAME FIRST MIDDLE LAST Frederick Christopher Herzog, Sr.				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth Potter				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes WWII		16b SOCIAL SECURITY NO. 122-09-2287		17 INFORMANT Ruth Herzog ADDRESS 12416 Surrey Circle Dr. Ft. Washington, Md.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE Ischemic heart disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 _____								
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE Augusto P. Rodriguez		TITLE (SPECIFY) Deputy		M.D.		DATE SIGNED 10-12-87		
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.		ADDRESS 5009 Rayburn Ct., Temple Hills, MD						

MEDICAL CERTIFICATION

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 10/15/87	23c NAME OF CEMETERY OR CREMATORY Resurrection Cemetery	23d LOCATION CITY OR TOWN COUNTY STATE Clinton P.G. Maryland
24 FUNERAL DIRECTOR NAME George P. Kalas Funeral Home		25a DATE REC'D BY REGISTRAR OCT 15 1987	
ADDRESS Oxon Hill, Md.		25b REGISTRAR'S SIGNATURE Julia Davidson-Randall	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN FIELD IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETURN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PRECISE IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM 101.3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

23a

(SPECIFY)

23b

DATE

23c

NAME OF CEMETERY OR CREMATORY

23d

LOCATION

CITY OR TOWN

COUNTY

STATE

24

FUNERAL DIRECTOR

NAME

25a

DATE REC'D. BY REGISTRAR

SIGNAL

NAME

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23a

(SPECIFY)

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DATE

23a

(SPECIFY)

23b

DATE

23c

NAME OF CEMETERY OR CREMATORY

23d

008712 03138W



065360 SEP 14 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

7a DATE KNOWN OF DEATH ☒ MONTH DAY YEAR 2b HOUR
ESTD ☐ 9 5 1987 M

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Willie Leroy Hill

3 SEX 4 RACE 5 DATE OF BIRTH MONTH DAY YEAR 6 AGE (IN YEARS) (LAST BIRTHDAY) 7c DATE PRONOUNCED DEAD MONTH DAY YEAR 7d HOUR
MALE BLACK FEB 18, 1953 34 YRS. 9 5 1987 2:54 P M

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) 7b CITIZEN OF WHAT COUNTRY? 8 MARRIED ☐ NEVER MARRIED ☒ 9 BALTIMORE CITY OR COUNTY OF DEATH
NORTH CAROLINA UNITED STATES WIDOWED ☐ DIVORCED ☐ Prince George's County MD

10 CITY OR TOWN OF DEATH 11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b KIND OF BUSINESS OR INDUSTRY
Cheverly Prince George's General Hospital Plumber helper PLUMBING

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE 13b COUNTY 13c CITY OR TOWN 13d INSIDE CITY LIMITS? YES ☒ NO ☐ 13e STREET ADDRESS
Wash., D.C. 2607 Jasper St., S.E. #1

14 FATHER'S NAME FIRST MIDDLE LAST 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
WILLIE HILL DAISY WILLIAMS

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) 16b SOCIAL SECURITY NO. 17 INFORMANT ADDRESS Washington, D.C.
NO 577 74 0519 DAISY MAE HILL-MOTHER-2607 Jasper St SE

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute narcotic intoxication
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a

19a DATE OF OPERATION 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? 20 AUTOPSY? YES ☒ NO ☐

21a EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 9-5- 19 87 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Subject used drugs
21d INJURY OCCURRED WHILE ☐ NOT WHILE ☒ AT WORK ☐ AT WORK 21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.) In a house 21f LOCATION STREET CITY OR TOWN COUNTY STATE
1305 Gates Street Seat Pleasant, Maryland

22a I certify that I took charge of the remains described above, held on Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒

ACTUAL SIGNATURE Margarita A. Korell TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 9/6/87

EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn St. Balto., MD.

23a BURIAL, CREMATION, REMOVAL (SPECIFY) 23b DATE 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION CITY OR TOWN COUNTY STATE
Burial 9/11/87 HARMONY MEMORIAL PARK LANDOVER, PG MARYLAND

24 FUNERAL DIRECTOR NAME ADDRESS 25a DATE REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE
ALEXANDER S. POPE-2617 Pennsylvania Avenue, S.E. SEP 10 1987 Julia Deider-Rendall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07 84 25AM

BHMH - 17
(VR A15 ME (5))

102300 SEP 14 83



100% COTTON
MADE IN THE U.S.A.

MADE IN THE U.S.A.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 30329

1- FOR STATE REGISTRAR		2a DATE OF DEATH MONTH DAY YEAR		2b HOUR	
DECEASED NAME (TYPE OR PRINT)		OCTOBER 11 1987		7:23P M	
3 SEX	4 RACE	5. DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR IF UNDER 24 HRS	
Female	Cauc.	July 15, 1892	95	MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH		
Russia	U.S.A.		Prince George's MD		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b KIND OF BUSINESS OR INDUSTRY		
Lanham	Doctors' Hospital of Pr. Geo Co.	Self-Employ.	Conf. Store		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET ADDRESS / ZIP CODE
Maryland	Pr. Geo.	N. Carr.	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		7600 Fontainebleau Dr.
14 FATHER'S NAME	15 MOTHER'S MAIDEN NAME	16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			
Morris Sniderman	Rose Unk.	No			
16b SOCIAL SECURITY NO.	17 INFORMANT	ADDRESS			
210-36-9656	Jule Hirschfield	9015 Spring Ave. Lanham, Md. 20706			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest.</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <i>Pneumonia.</i>					
DUE TO, OR AS A CONSEQUENCE OF <i>Chronic Heart Failure.</i>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Severe Degenerative Joint Disease</i>					
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY?	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21c OF PART 2)			
21d INJURY OCCURRED	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <i>8-21-84</i> to <i>10-11-87</i> that (I) (we) last saw the deceased alive on <i>10-11-87</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE	DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED		
<i>Stephen P. Cross</i>	<i>M.D.</i>		<i>10/12/87</i>		
22d PHYSICIAN'S NAME (TYPE OR PRINT)	22e ADDRESS				
<i>Stephen P. Cross</i>	<i>5711 S. Aris Ave Suite 302 Riverdale, Md</i>				
23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION CITY OR TOWN COUNTY STATE		
Burial	10/14/87	Beth Shalom Cem.	Township Of Shaler PA		
24 FUNERAL DIRECTOR		DATE RECEIVED BY REGISTRAR			
Rendon/Hale Lanham Fun'l Home		OCT 19 1987			
9013 Annapolis Rd. Lanham, Md. 20706		REGISTRAR'S SIGNATURE <i>Julia Davidson Rendon</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

000112 OCT 20 67

LOS ANGELES

TO: DIRECTOR, FBI
FROM: SAC, LOS ANGELES
SUBJECT: [Illegible]
[The remainder of the teletype message is illegible due to extreme fading.]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

LORENZO

D

HISER

2a. DATE OF DEATH

MONTH

DAY

YEAR

2b. HOUR

10

23

10.50am

3 SEX

Male

4 RACE

Caucasian

5. DATE OF BIRTH

November

21,

1907

6 AGE (IN YEARS LAST BIRTHDAY)

79

YRS

7a. BIRTHPLACE
(STATE OR FOREIGN
COUNTRY)

West Virginia

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8 MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

PRINCE GEORGES COUNTY

MD

10 CITY OR TOWN OF DEATH

CLINTON MD

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN BALTIMORE, GIVE STREET ADDRESS)

SOUTHERN MARYLAND HOSPITAL

12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)

ticket agent

12b. KIND OF BUSINESS OR
INDUSTRY

railroad

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MD

13b. COUNTY

Pr. George's Temple Hill

13c. CITY OR TOWN

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE

5103 Durand Street

20748

14 FATHER'S NAME

Alman

MIDDLE

K.

LAST

Hathaway

15 MOTHER'S MAIDEN NAME

Gayle

MIDDLE

LAST

UNK.

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)

no

n/a

16b. SOCIAL SECURITY NO.

224-26-2914

17 INFORMANT

step-son Lee Gladwin

ADDRESS

Rte 3, Box 225
Winchester, VA 2260118 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Cardiorespiratory Collapse

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

one hour

DUE TO, OR AS A CONSEQUENCE OF

(b) Atherosclerotic Cardiovascular Disease

10 yrs

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Diabetes mellitus

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 2, OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM ETC.)21f. LOCATION
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 10-1 1987 to 10-23- 1987, that (I) last
saw the deceased alive on 10-23 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (If we jointly did not view the body after death.)

22b. SIGNATURE

Thomas F. Cleary M.D.

DEGREE

ATTENDING
PHYSICIAN ☒MEDICAL
DIRECTOR ☐STAFF
PHYSICIAN ☐

22c. DATE SIGNED

10-24-87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Thomas F. Cleary, M.D.

22e. ADDRESS

9131 Piscataway Rd., Clinton, MD 20735

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Cremation

23b. DATE

Oct 24, 1987

23c. NAME OF CEMETERY OR CREMATORY

Lee Crematory

23d. LOCATION
(CITY OR TOWN)

Clinton, Prince George's MD

24 FUNERAL DIRECTOR

Lee Funeral Home, Inc.

Old Alexander Ferry Rd., Clinton, MD

25a. DATE REC'D BY REGISTRAR

Oct 28 1987

25b. REGISTRAR'S SIGNATURE

John T. Anderson-Randall

0520 00120 03

PLEASE

070179 0012987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 7 3 0 3 3 1

FOR STATE REGISTRAR		FIRST		MIDDLE		LAST		2a DATE OF DEATH		MONTH		DAY		YEAR		2b HOUR	
1 DECEASED NAME (TYPE OR PRINT)		ALFRED		C.		HOGAN		10-22-87								12.40AM	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE		(IN YEARS (LAST BIRTHDAY))		7 UNDER 1 YEAR		8 UNDER 2 HRS					
MALE		WHITE		MAY 15, 1921		66		YRS		MONTHS		DAYS		HOURS		MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH											
S. CAROLINA		U.S.A.		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		PRINCE GEORGES										MD	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY											
CHEVERLY		PRINCE GEORGES HOSPITAL CENTER		CARPENTER		CONSTRUCTION											
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS / ZIP CODE									
Md.		CALVERT		OWINGS		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		BOX 180								20736	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME															
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST							
JOHN		HOGAN				EFFIE		BOYCE									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS											
YES		WWII		249-12-7109		MELODY PAYNE		4409		34th ST.,		BRENTWOOD, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY		IMMEDIATE CAUSE (a)		Respiratory arrest.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		b)		Emphysema, end stage													
		c)		Organic Brain Syndrome													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I																	
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c HOW INJURY OCCURRED		(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
		P.M. 19															
21d INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a I certify that (I) (this hospital) attended the deceased from		10-15		1987		to		10-22		1987		that (I) (we) last saw the deceased alive on		10-22		1987	
22b SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED											
R. arena		M.D.				10/22/87											
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS															
RAKESH ARORA		14300 GALLANT FOX LA, Bowie, Md															
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN		COUNTY		STATE							
BURIAL		10-24-1987		CEDAR HILL CEMETERY		SUITLAND,		P.G.C.		Md.							
24 FUNERAL DIRECTOR NAME		ADDRESS		25a DATE REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE											
W. W. CHAMBERS CO.		RIVERDALE, Md. 20737		OCT 28 1987													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1

068245 OCT 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a DATE OF DEATH MONTH DAY YEAR		2b HOUR	
Betty Nicoll Holland				October 5, 1987		115 PM	
3 SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7 UNDER 24 YRS	
Female	Caucasian	July 4 1922		65			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Baltimore, Md.	US			Prince Georges County			
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a TYPE OF WORK (FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Laurel	Greater Laurel Beltsville Hospital			Housewife		Home	
13a STATE		13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS / ZIP CODE		
Md.	P.G.	Laurel			200 Ft. Meade Rd. #1510 20707		
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
William		Nicoll		Agusta Bond			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS			
n/a		n/a		219-24-2901 David Holland, Sr. same as 13e			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) HEPATIC ENCEPHALOPATHY						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						YEARS	
DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC LIVER CIRRHOSIS							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ASPIRATION PNEUMONIA, PEPTIC ULCER DISEASE							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from		OCT 5 1987		Ave 1985 to Oct 1987		that (I) (we) last saw the deceased alive on	
above (I) (we) (did/did not) view the body after death.							
22b SIGNATURE		DEGREE		22c DATE SIGNED			
ESMACHAD		MD		10/5/87			
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS		22f DATE REC'D BY REGISTRAR		22g REGISTRAR'S SIGNATURE	
		321 PRINCE GEORGE ST		OCT 8 1987		Julia Davidson-Randall	
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION CITY OR TOWN COUNTY STATE			
Burial		10/8/87	Ivy Hill Cemetery	Laurel P.G. Maryland			
24 FUNERAL DIRECTOR NAME ADDRESS				25a DATE REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Fleck Funeral Home, Inc. Laurel, Md.				OCT 8 1987		Julia Davidson-Randall	

BP

069498 OCT 23 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) FIRST MARY L. LAST Holland			2a DATE OF DEATH MONTH DAY YEAR 10-12-87		2b HOUR 10:50 AM
3 SEX Female	4 RACE Black	5 DATE OF BIRTH MONTH DAY YEAR Feb. 28, 1907		6 AGE (IN YEARS (LAST BIRTHDAY)) 80 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD	
10 CITY OR TOWN OF DEATH LAUREL	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel/Beltsville Hosp.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING TIME) Housewife		12b KIND OF BUSINESS OR INDUSTRY
13a STATE Md.		13b COUNTY Howard	13c CITY OR TOWN Jessup	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Thomas Matthews		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hattie Davis			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES IF KNOWN) (IF YES, GIVE WAR OR DATES) NO		16b SOCIAL SECURITY NO 318-09-6753		17 INFORMANT ADDRESS Jeanette Young (niece) 3190 Mission Rd. Jessup, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Corda. Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Acute Hemorrhagic Cerebrovascular accident DUE TO, OR AS A CONSEQUENCE OF (c) Severe Hypertension					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22 I certify that (I) (this hospital) attended the deceased from 19 30 to 10/12 19 57 that (I) (we) last saw the deceased alive on 10/12 19 57, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (did not) view the body after death.					
22b SIGNATURE William A. Warner		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10/12/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) W A Warner		22e ADDRESS 321 Prince George St Laurel 20707			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10-20-87	23c NAME OF CEMETERY OR CREMATORY Md Nat'l Mem. Park		23d LOCATION CITY OR TOWN COUNTY STATE Laurel, Pr. Geo., MD
24 FUNERAL DIRECTOR NAME George R. Snowden		ADDRESS Rockville, MD 20850		25a DATE REC'D BY REGISTRAR OCT 19 1987	
				25b REGISTRAR'S SIGNATURE Julia Sanders-Randall	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove all other papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 above, injury, or other traumatic event, the medical examiner must be notified at once.

0 8 8 4 3 0 0 0 1 5 7 0 1

1. The first part of the paper is devoted to a general discussion of the problem of the origin of life. It is shown that the problem is one of the most important and interesting in the history of science, and that it has been the subject of much speculation and controversy. The author then proceeds to discuss the various theories which have been advanced to explain the origin of life, and to show that the most plausible of these is the theory of spontaneous generation.

069624 OCT 26 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

30334

1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE KNOWN OF DEATH			MONTH DAY YEAR			2b HOUR			
James Franklin Hooe						10-18			1987			M			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS)		IF UNDER 1 YR		IF UNDER 24 HRS		7c DATE PRONOUNCED DEAD		2d HOUR	
Male		White		10-11-53		34 YRS.		MONTHS DAYS		HOURS MIN		10-18		8710P	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b CITIZEN OF WHAT COUNTRY?				8 MARRIED				9 BALTIMORE CITY OR COUNTY OF DEATH			
Washington DC				USA				WIDOWED NEVER MARRIED DIVORCED				Prince George			
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a USUAL OCCUPATION (TYPE OF WORK)				12b KIND OF BUSINESS OR INDUSTRY			
Cheverly				Prince Georges General Hospital				Maintenance Eng				Housing			
13a USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b COUNTY				13c CITY OR TOWN				13d INSIDE CITY LIMITS?			
Virginia								Alexandria				YES NO			
13e STREET ADDRESS				13f CITY OR TOWN				13g STATE				13h ZIP CODE			
8400 Sky View Drive Apt T3															
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME				16a WAS DECEASED EVER IN U.S. ARMED FORCES?				16b SOCIAL SECURITY NO			
James I Hooe				Francis Loretta Ennis				NO				217-64-9504			
17 INFORMANT				18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			
Frances B Hooe				PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio myopathy</u>				19c AUTOPSY?				YES NO			
Same as #13				(b) <u>Due to, or as a consequence of</u>											
				(c) <u>Due to, or as a consequence of</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1															
20a EXTERNAL CAUSE WAS				20b TIME OF INJURY				20c HOW INJURY OCCURRED				20d LOCATION			
UNDERLYING OR CONTRIBUTING CAUSE OF DEATH				HOUR A.M. MONTH DAY YEAR				ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2				CITY OR TOWN COUNTY STATE			
21a INJURY OCCURRED				21b PLACE OF INJURY				21c LOCATION				21d LOCATION			
WHILE AT WORK NOT WHILE AT WORK				STREET, FACTORY, FARM, ETC.				STREET CITY OR TOWN COUNTY STATE				CITY OR TOWN COUNTY STATE			
22a I certify that I took charge of the remains described above, held on death resulted from				Autopsy Inspection Inquiry				22b I certify that I took charge of the remains described above, held on death resulted from				Autopsy Inspection Inquiry			
Natural causes Accident Suicide Homicide Undetermined manner															
23a ACTUAL SIGNATURE				23b TITLE (SPECIFY)				23c DATE SIGNED				23d REGISTRAR'S SIGNATURE			
Augusto P. Rodriguez				Deputy				10-19-87							
24 EXAMINER'S NAME				25a DATE REC'D BY REGISTRAR				25b REGISTRAR'S SIGNATURE				25c REGISTRAR'S SIGNATURE			
Augusto P. Rodriguez, M.D.				5009 Rayburn Ct., Temple Hills, MD											
26a BURIAL, CREMATION, REMOVAL				26b DATE				26c NAME OF CEMETERY OR CREMATORY				26d LOCATION			
Burial				22Oct1987				National Memorial Park				Falls Church Va			
27 FUNERAL DIRECTOR				28a DATE REC'D BY REGISTRAR				28b REGISTRAR'S SIGNATURE				28c REGISTRAR'S SIGNATURE			
Robert E Wilhelm				Funeral HOME				Suitland, Md.				OCT 23 1987			

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PREVIOUS ITEM 18, GIVE PAGES 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PMA-1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (1))

000024 10-11-53

10-11-53
10-11-53

James Franklin
10-11-53

James Franklin



James Franklin

10-11-53

000024 10-11-53

069199 OCT 20 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

30333

1 DECEASED NAME (TYPE OR PRINT) <i>Dorothy Howell</i>						2a DATE KNOWN OF DEATH MONTH DAY YEAR <i>Oct 3 1987</i>					
3 SEX <i>F</i>	4 RACE <i>W</i>	5 DATE OF BIRTH MONTH DAY YEAR <i>Apr 15 27 60</i>	6 AGE (IN YEARS) LAST BIRTHDAY <i>60</i> YRS	IF UNDER 1 YR MONTHS DAYS HOURS MIN	IF UNDER 24 HRS	2c DATE PRONOUNCED DEAD MONTH DAY YEAR <i>Oct 3 1987</i>		2d HOUR <i>8:47</i> P M			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>VIRGINIA</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges</i>					
10 CITY OR TOWN OF DEATH <i>Laurel</i>		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION <i>Greater Laurel Baltimore Hosp</i>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>WELDER</i>		12b KIND OF BUSINESS OR INDUSTRY <i>MANUFACTURING CO</i>			
13a STATE <i>Md</i>		13b COUNTY <i>ANNE ARUNDEL</i>		13c INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d STREET ADDRESS <i>20702 Red Clay Rd</i>					
14 FATHER'S NAME FIRST MIDDLE LAST <i>JOHN TAYLOR</i>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>MARGARET ANN MYERS</i>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>NO</i>				16b SOCIAL SECURITY NO <i>—</i>		17 INFORMANT ADDRESS <i>CAROL VOORITES - ABOVE</i>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute Myocardial Dis.</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last } (b) <i>Chronic Myocardial Dis.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>—</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <i>None</i>											
19a DATE OF OPERATION <i>None</i>				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>— P.M. 19</i>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>John P. Rogers</i>				TITLE (SPECIFY) <i>M.D. D.E.P.</i>				MEDICAL EXAMINER DATE SIGNED <i>Oct 4 1987</i>			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>CREMATION</i>				23b DATE <i>OCT 8, 1987</i>		23c NAME OF CEMETERY OR CREMATORY <i>WESTVIEW MEM.</i>		23d LOCATION CITY OR TOWN COUNTY STATE <i>CATONSVILLE MI</i>			
24 FUNERAL DIRECTOR NAME <i>DONALDSON FUNERAL HOME, LAUREL MD</i>				ADDRESS		25a DATE REC'D. BY REGISTRAR <i>OCT 13 1987</i>		25b REGISTRAR'S SIGNATURE <i>Julia Twidorn-Rudner</i>			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

08130100



RECEIVED 10/10/00

WINTERHILL



1275
071281 NOV

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

30330
REG NO

1- STATE B- REGISTRAR		FOR		DATE		30330	
DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST	
Frances Addison Huff							
3 SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS) (LAST BIRTHDAY)	7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH
Female	Black	May 10, 1913	74 YRS	MD	USA		Prince George's County MD
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY		
Clinton	6805 Birch Lane		Housewife				
13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS			
Maryland	Prince George's	Clinton		6805 Birch Lane / 20748			
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			
Augustus Dorsey		Jessie Griffin		No			
16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS			
577-24-1403		Thurmon Huff (Husband)		same as #13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial disease.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I							
None							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
None							
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
				None			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED	
<i>John S. Rogers</i>		Deputy		1919 Seminary Road		10/29/87	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		23a BURIAL, CREMATION, REMOVAL (SPECIFY)			
John S. Rogers, M.D.		Silver Spring, Montgomery County, MD		Burial			
23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE			
11-2-87		Md. National Mem. Park		Laurel, Pr. Geo., Maryland			
24 FUNERAL DIRECTOR NAME		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
George R. Snowden		NOV 02 1987		<i>George R. Snowden</i>			
Rockville, MD 20850							

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PLACE OF PART 1. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW-3. RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

John S. Hoxby

069625 OCT 26 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been completed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1- FOR
STATE
REGISTRAR

2- DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

DEBEBE

HURISSIE

2a DATE OF DEATH

MONTH

DAY

YEAR

10-18-87

2b HOUR

P

M

4:15

3 SEX

male

4 RACE

BLACK

5 DATE OF BIRTH

MONTH

DAY

YEAR

7 18 39

6 AGE (IN YEARS LAST BIRTHDAY)

48

YRS

IF UNDER 1 YEAR

IF UNDER 24 HRS

MONTHS

WEEKS

HOURS

MIN.

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Ethiopia

7b CITIZEN OF WHAT COUNTRY?

Ethiopia

8 MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Prince George's CO

MD

10 CITY OR TOWN OF DEATH

Riverdale

11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Leland Memorial Hospital

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Diplomat

12b KIND OF BUSINESS OR INDUSTRY

Ethiopia Government

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

Maryland

13b COUNTY

P.G. CO

13c CITY OR TOWN

Hyattsville

13d INSIDE CITY LIMITS?

YES ☒NO ☐

13e STREET ADDRESS / ZIP CODE

3513 Toledo Terr / 20737

MT H-2

14 FATHER'S NAME

Hurissie

MIDDLE

LAST

Dhagab

15 MOTHER'S MAIDEN NAME

Galashe

MIDDLE

LAST

Odaa

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

no

16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)

17 INFORMANT

577-06-0349

18 CAUSE OF DEATH

Sisai Ibssa

3351 MT. Pleasant St. N.W.

Wash D.C.

PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

CARDIAC ARREST

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost

b) ACUTE ANTERIOR MYOCARDIAL INFARCTION

4 Hrs

DUE TO, OR AS A CONSEQUENCE OF

INFARCTION

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

DIABETIS MELLITUS

19a DATE OF OPERATION

N/A

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

YES ☐NO ☒

20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐NO ☐21a ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c HOW INJURY OCCURRED

(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)

21f LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a I certify that (I) (this hospital) attended the deceased from 10-18-1987 to 10-18-1987 that (I) (we) last saw the deceased alive on 10-18-1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did (did not) view the body after death.

22b SIGNATURE

K. J. M. A. THEW

DEGREE

M.D.

ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c DATE SIGNED

10/19/87

22d PHYSICIAN'S NAME (TYPE OR PRINT)

K. J. M. A. THEW

22e ADDRESS

6511 Kenilworth Ave Riverdale, MD 20737

23a BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)

Burial

23b DATE

10/20/87

23c NAME OF CEMETERY OR CREMATORY

Glenwood Cemetery

23d LOCATION

CITY OR TOWN

COUNTY

STATE

Wash. D.C. D.C. D.C.

24 FUNERAL DIRECTOR

W.W. Chambers CO. INC

ADDRESS

5801 Cleveland Ave Riverdale Md.

OCT 23 1987

25b REGISTRAR'S SIGNATURE

10/23/87

84

18

7

Black

male

21/10/10

21/10/10

21/10/10

21/10/10

21/10/10

21/10/10

21/10/10

21/10/10

21/10/10

21/10/10

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21/10/10

21/10/10

21/10/10

21/10/10

21/10/10

21/10/10

21/10/10

21/10/10

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT)		2a DATE KNOWN OF DEATH		2b HOUR	
ALAN BERNARD JACKSON		10-16-87		M	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE	7a BIRTHPLACE	7b CITIZEN OF WHAT COUNTRY?
Male	Black	Jan. 31, 1960	27 YRS	Ohio	USA
8 MARRIED		9 BALTIMORE CITY OR COUNTY OF DEATH		10 CITY OR TOWN OF DEATH	
NEVER MARRIED		Prince George's County		Cheverly	
WIDOWED		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a USUAL OCCUPATION	
DIVORCED		Prince George's County Hospital		Security Guard	
13a STATE		13b COUNTY		13c CITY OR TOWN	
Maryland		P.G.		Suitland	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES?	
Willie Jackson		Stella (Unknown)		no	
16b SOCIAL SECURITY NO.		17 INFORMANT		18 CAUSE OF DEATH	
281 60 3284		Janice Jackson-wife-4227 29th St., Suitland, Maryland		Multiple gunshot wounds	
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH	
21a EXTERNAL CAUSE WAS		21b TIME OF INJURY		21c HOW INJURY OCCURRED	
UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		2:40 PM 10-16-87		subject shot by police	
21d INJURY OCCURRED		21e PLACE OF INJURY		21f LOCATION	
WHILE AT WORK		home		4864 Eastern Lane #302 Suitland, Maryland	
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Margarita A. Korell, M.D.		Assistant		10-17-87	
EXAMINER'S NAME		ADDRESS		23a BURIAL, CREMATION, REMOVAL	
(TYPE OR PRINT)		111 Penn Street		Burial	
23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION	
Oct. 24, 1987		Harmony Memorial Park Landover, Md.		23e DATE REC'D BY REGISTRAR	
23f REGISTRAR'S SIGNATURE		23g REGISTRAR'S SIGNATURE		23h REGISTRAR'S SIGNATURE	
Stewart Funeral Home-4001 Benning Road, N		NOV 02 1987		Julia Davidson-Randall	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

070224 101-301

AM

20% COTTON FIBER

WILSON



68835 OCT 16

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

30339

REG. NO.

DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Joseph

Al.

Jackson

2a DATE KNOWN OF DEATH
ESTIMATED
MONTH DAY YEAR
10-12-87

3 SEX

Male

4 RACE

Black

5 DATE OF BIRTH

7-30-30

6 AGE (IN YEARS)

57 YRS.

IF UNDER 1 YR

MONTHS DAYS HOURS MIN

IF UNDER 24 HRS

2c DATE PRONOUNCED DEAD

10-12-87

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Md.

7b CITIZEN OF WHAT COUNTRY?

U.S.A.

8 MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☒

9 BALTIMORE CITY OR COUNTY OF DEATH

Prince George's

10 CITY OR TOWN OF DEATH

Cheverly

11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF IN SUCH FACILITY, GIVE STREET ADDRESS)

Prince George's Gen. Hosp.

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Ret.-Veteran

12b KIND OF BUSINESS OR INDUSTRY

U.S.Gov't.

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

Md.

13b COUNTY

P.G.

13c CITY OR TOWN

Seat Pleasant

13d INSIDE CITY LIMITS?

YES ☒ NO ☐

13e STREET ADDRESS

504 62nd Pl. # B

14 FATHER'S NAME

John

MIDDLE

R.

LAST

Jackson

15 MOTHER'S MAIDEN NAME

Marie

MIDDLE

Tolson

16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)

Yes

16b SOCIAL SECURITY NO.

'51-'56

17 INFORMANT

ADDRESS

578-36-8422

Marie L. Madison-Same as # 13 above

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

Sudden cardiac death

(b) DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED?

20 AUTOPSY?

YES ☐ NO ☒

21a EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b TIME OF INJURY

HOUR A.M. MONTH DAY YEAR
P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a I certify that I took charge of the remains described above, held on

Autopsy ☐Inspection ☒Inquiry ☒

and in my opinion

death resulted from

Natural causes ☒Accident ☐Suicide ☐Homicide ☐Undetermined manner ☐

ACTUAL SIGNATURE

Augusto P. Rodriguez

TITLE (SPECIFY)

Deputy

MEDICAL EXAMINER

DATE SIGNED

10-12-87

EXAMINER'S NAME
(TYPE OR PRINT)

Augusto P. Rodriguez, M.D.

ADDRESS

5009 Rayburn Ct, Temple Hills, MD

23a BURIAL, CREMATION, REMOVAL
(SPECIFY)

23b DATE

10/19/87

23c NAME OF CEMETERY OR CREMATORY

ARLINGTON MTL. CEM. PT. MYER

23d LOCATION
(CITY OR TOWN)

COUNTY

STATE

24 FUNERAL DIRECTOR

NAME

ADDRESS

H. S. WASHINGTON & SONS 4925 BURROUGHS AVE

25a DATE REC'D. BY REGISTRAR

OCT 15 1987

25b REGISTRAR'S SIGNATURE

John Deaton

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PLACE OF ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07-84
25M

BP

DHMH-17
(VR A15 ME (1))

833 330 3131

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70735 NOV-4 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOSEPH CARL JANOWIAK			2a DATE OF DEATH MONTH DAY YEAR OCTOBER 29 1987		2b HOUR 0855a M
3 SEX Male	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR 11 6 1919		6 AGE (IN YEARS LAST BIRTHDAY) 67 YRS	7 UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD	
10 CITY OR TOWN OF DEATH Andrews A.F.B.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Malcolm Grow Medical Center		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U.S. Army - Ret.	12b KIND OF BUSINESS OR INDUSTRY Military	
13a STATE Maryland		13b COUNTY Prince George	13c CITY OR TOWN Temple Hills	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 6108 Harley Lane 20748
14 FATHER'S NAME FIRST MIDDLE LAST John Janowiak			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Angeline Osowaska		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WWII, Korea, V-N		16b SOCIAL SECURITY NO. 319-16-9095		17 INFORMANT Helen Janowiak	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (this hospital) attended the deceased from <u>15 OCTOBER</u> 19 <u>87</u> to <u>29 OCTOBER</u> 19 <u>87</u> that (we) last saw the deceased alive on <u>29 OCTOBER</u> 19 <u>87</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above; (I) <input checked="" type="checkbox"/> (did) <input type="checkbox"/> not view the body after death.					
22b SIGNATURE <i>Loretta M. O'Brien</i>				22c DATE SIGNED 29 OCTOBER 87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) LORETTA M. O'BRIEN				22e ADDRESS MALCOLM GROW USAF MEDICAL CENTER, AAFB MD	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 11/3/87	23c NAME OF CEMETERY OR CREMATORY Arlington National Cem.		23d LOCATION CITY OR TOWN COUNTY Arlington Virginia 20331-5300	
24 FUNERAL DIRECTOR NAME George P. Kalas Funeral Home		25a ADDRESS 6160 Oxon Hill Rd. Oxon Hill, Md.		25b DATE REC'D. BY REGISTRAR NOV 03 1987	
25c REGISTRAR'S SIGNATURE <i>Julia Gordon-Randall</i>					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined by a physician within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and checked in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove embalmers' pages. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

104-101 2870

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104-101 2870

104-101 2870

068996

OCT 20 87

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

30341

DECEASED NAME (TYPE OR PRINT) HELEN JOHNSON			2a DATE OF DEATH MONTH DAY YEAR 9-15-87		2b HOUR 2:03 P.M.
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR Nov. 19, 1903		6 AGE (IN YEARS, LAST BIRTHDAY) 83 YRS	7 UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD	
10 CITY OR TOWN OF DEATH CLINTON	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b KIND OF BUSINESS OR INDUSTRY Own Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md.			13b COUNTY Pr. Geo's	13c CITY OR TOWN Clinton	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST Joseph -- Jordan			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary -- (Unknown)		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) --		17 INFORMANT Mary Donahue- 5540 Exeter St., Churchton, Md. 20733	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction (Septic shock) DUE TO, OR AS A CONSEQUENCE OF (c) Hypovolemic Hypotension PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9-15-87		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18B PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (1) this hospital attended the deceased from 9-15-87 to 9-15-87 that (1) (we) last saw the deceased alive on 9-15-87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (2) (we) (did) (did not) view the body after death.					
22b SIGNATURE Abul Hasan U Ansari		DEGREE MD		22c DATE SIGNED 9-15-87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) ABULHASAN U ANSARI		22e ADDRESS 8926 Woodyard Rd, Suite 101, Clinton Md. 20735			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b DATE SEPT. 20, 87	23c NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA, VIRGINIA
24 FUNERAL DIRECTOR Richard A. Coleman		Upper Marlboro, Md. 20772		25a DATE REC'D BY REGISTRAR OCT 19 1987	

Funeral Home

Upper Marlboro, Md. 20772

DATE REC'D BY REGISTRAR
OCT 19 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial or cremation permit. These permits are issued by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, show any injury or other traumatic event, the medical examiner must be notified of a death.

BP

068169 OCT

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificates pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked of item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH: 16-60M 7/84
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
FOR STATE REGISTRAR					REG. NO.							
1 DECEASED NAME (TYPE OR PRINT) JAMES JOHNSON					2a DATE OF DEATH MONTH DAY YEAR OCTOBER 2 1987					2b HOUR 12:10P _M		
3 SEX Male		4 RACE Black		5 DATE OF BIRTH March 30 1928		6 AGE (IN YEARS LAST BIRTHDAY) 59		7 IF UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD						
10 CITY OR TOWN OF DEATH Lanham		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor		12b KIND OF BUSINESS OR INDUSTRY Construction				
13a STATE Maryland					13b COUNTY P. Georges		13c CITY OR TOWN Landover		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 7613 Muncy Road/20785	
14 FATHER'S NAME FIRST MIDDLE LAST John Aaron -Aaron			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Mae Henderson									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 239385595			17 INFORMANT 7613 Ursula Johnson			7713 Muncy Road Landover, Md. 20785			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Ca Colon with metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT IF UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18B PART 1 OR PART 2)						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE						
22a I certify that (I) (this hospital) attended the deceased from <u>9/28/87</u> to <u>OCT 2</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>OCT 2</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b SIGNATURE <u>Rita K. Shan</u>						DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <u>10/31/87</u>		
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>GRITA K. SHAN</u>						22e ADDRESS <u>14333 Laurel Bowie Rd. Landover MD</u>						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 10-7-87		23c NAME OF CEMETERY OR CREMATORY Harmony Memorial Park			23d LOCATION CITY OR TOWN COUNTY STATE Landover P.G. Md.				
24 FUNERAL DIRECTOR J.B. Jenkins Funeral Home 7474 Landover Road Landover, Md. 20785						25a DATE REC'D. BY REGISTRAR OCT - 8 1987		25b REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>				

069982 OCT 29 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21202

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM-PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			7a DATE KNOWN OF DEATH ESTIMATED			7b HOUR		
Lillie M. Johnson						10-24-87			M		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS)	IF UNDER 1 YR	IF UNDER 24 HRS	7c DATE PRONOUNCED DEAD			7d HOUR		
Female	BLACK	APR 15 1910	77 YRS.			10-24-87			4:30 P M		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED			9 BALTIMORE CITY OR COUNTY OF DEATH		
SOUTH CAROLINA			U.S.A.			WIDOWED			P.D. MD		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY		
CLINTON			SOUTHERN MARYLAND HOSPITAL			HOUSEKEEPING			COLLEGE		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a STATE			13b COUNTY			13c CITY OR TOWN		
			M.D.			P.G.			UPPER MARLBORO		
						13d INSIDE CITY LIMITS?			13e STREET ADDRESS		
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			15205 PERLESS AVE 20722		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			16a WAS DECEASED EVER IN U.S. ARMED FORCES?			16b SOCIAL SECURITY NO.		
ARTHUR			CHARLOTTE			NO			220-16-8828		
17 INFORMANT			18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		
JAMES JOHNSON			15205 PERLESS AVE UPPER MARLBORO MARYLAND								
			PART 1 DEATH WAS CAUSED BY:								
			IMMEDIATE CAUSE (a) <u>Ischemic heart disease</u>								
			DUE TO, OR AS A CONSEQUENCE OF								
			Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last								
			(b)								
			DUE TO, OR AS A CONSEQUENCE OF								
			(c)								
			PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1								
20a EXTERNAL CAUSE WAS			20b TIME OF INJURY			20c HOW INJURY OCCURRED			20d AUTOPSY?		
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			P.M. 19			ENTER NATURE OF INJURY IN ITEM 18 PART 2 OR PART 2			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a INJURY OCCURRED			21b PLACE OF INJURY (AT HOME STREET FACTORY FARM, ETC.)			21c LOCATION			21d CITY OR TOWN		
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>						STREET			COUNTY		
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>						CITY OR TOWN			STATE		
22a I certify that I took charge of the remains described above, held an			Autopsy <input type="checkbox"/>			Inspection <input checked="" type="checkbox"/>			Inquiry <input checked="" type="checkbox"/>		
death resulted from:			Natural causes <input checked="" type="checkbox"/>			Accident <input type="checkbox"/>			Suicide <input type="checkbox"/>		
			Homicide <input type="checkbox"/>			Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED					
Augusto P. Rodriguez			Deputy			10-24-87					
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS			MEDICAL EXAMINER					
Augusto P. Rodriguez, M.D.			5009 Rayburn Ct, Temple Hills, MD								
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (CITY OR TOWN)		
BURIAL			10-30-87			RESURRECTION CEMETERY			CLINTON P.G. MARYLAND		
24 FUNERAL DIRECTOR NAME			25a DATE REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE					
ROLLINS FUNERAL HOME, INC.			OCT 27 1987			Julia Davidson-Rodriguez					
4339 HUNT PLACE, N.E.			WASHINGTON, D.C. 20019								

67-84
25M

BP

DHMH - 17
(VR A15 ME (5))

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STATIONER & PRINTER, 100 N. 1st St., St. Paul, Minn.

STATIONER & PRINTER, 100 N. 1st St., St. Paul, Minn.

067885 OCT -87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

30344

1 DECEASED NAME (TYPE OR PRINT) SHIRLEY A. F. JOHNSON			2a DATE OF DEATH MONTH DAY YEAR 10 05 87		2b HOUR 8:30 AM
3 SEX FEMALE	4 RACE BLACK	5 DATE OF BIRTH MONTH DAY YEAR 05 23 55		6 AGE (IN YEARS LAST BIRTHDAY) 32 YRS	7 UNDER 1 YEAR MONTH DAY HOUR MIN 8 UNDER 24 HRS MONTH DAY HOUR MIN
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D. C.	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD	
10 CITY OR TOWN OF DEATH CHEVERLY	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S HOSPITAL CENTER		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unknown	12b KIND OF BUSINESS OR INDUSTRY None	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md.		13b COUNTY P.G.	13c CITY OR TOWN Kentland	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 6535 Columbia Terrace 20785
14 FATHER'S NAME FIRST MIDDLE LAST James Faison		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosetta Simmons			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO 578-84-2034	17 INFORMANT ADDRESS Mrs. Rosetta Faison/mother/same as 13e		
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Invasive Aspergillosis (presumptive)</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) <u>Steroid Use</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Severe Pulmonary Sarcoidosis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>hrs -</u>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (1) (this hospital) attended the deceased from 9/29/87 to 10/5/87 that (2) (we) lost saw the deceased alive on 9/29/87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (3) (we) did not view the body after death.					
22b SIGNATURE Michael Berard, MD		DEGREE		22c DATE SIGNED 10/6/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Michael Berard		22e ADDRESS 7100 BALTIMORE AVE 401 COLLEGE PARK, MD 20740			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 10-10-87	23c NAME OF CEMETERY OR CREMATORY HARMONY MEM. PARK	23d LOCATION CITY OR TOWN COUNTY STATE LANDOVER P.G. MD.		
24 FUNERAL DIRECTOR NAME John T. Rhines		25a DATE REC'D. BY REGISTRAR OCT 7 1987		25b REGISTRAR'S SIGNATURE Julia Davis-Randall	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

068114 OCT-1987

Copy

Division of Vital Records, 201 W. Preston St., Baltimore, Maryland 21201

Released by the Registrar

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1 DECEASED NAME (TYPE OR PRINT) ELSIE P. JONES					2a. DATE OF DEATH MONTH DAY YEAR 10-4-87				
3 SEX FEMALE					2b. HOUR 4:40 PM				
4 RACE BLACK					5 DATE OF BIRTH NOV. 22, 1900				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.					6 AGE (IN YEARS LAST BIRTHDAY) 86				
7b CITIZEN OF WHAT COUNTRY? UNITED STATES					8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				
10 CITY OR TOWN OF DEATH CLINTON					9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD				
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL					12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DOMESTIC				
12b KIND OF BUSINESS OR INDUSTRY PRIVATE									
13a STATE MARYLAND					13b COUNTY P.G.				
13c CITY OR TOWN TEMPLE HILLS					13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13e STREET ADDRESS / ZIP CODE 6517 Northam Road 20748									
14 FATHER'S NAME FIRST MIDDLE LAST HENRY PROCTOR					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JULIA UNK				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) NO					16b SOCIAL SECURITY NO				
17 INFORMANT SHIRLEY BROWN-DAUGHTER-6517 Northam Rd					ADDRESS Temple Hill, Md.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1 DEATH WAS CAUSED BY									
IMMEDIATE CAUSE (a) Pneumonia									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
(b) _____									
DUE TO, OR AS A CONSEQUENCE OF									
(c) _____									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1									
19a DATE OF OPERATION									
19b CONDITION FOR WHICH OPERATION WAS PERFORMED									
20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19									
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>									
21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)									
21f LOCATION STREET CITY OR TOWN COUNTY STATE									
22a I certify that (1) this hospital attended the deceased from 5-2 , 19 71 to 10-4 , 19 87 that (1) (we) last saw the deceased alive on 9-12 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (2) (we) (did not) view the body after death.									
22b SIGNATURE William Hunt Hunt MD DEGREE MD									
22c DATE SIGNED 10-4-87									
22d PHYSICIAN'S NAME (TYPE OR PRINT) William Hunt Hunt									
22e ADDRESS 11701 LIVINGSTON RD #101 F.W.H.S.H. 20746									
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL									
23b DATE 10/9/87									
23c NAME OF CEMETERY OR CREMATORY LINCOLN MEMORIAL CEM.									
23d LOCATION CITY OR TOWN COUNTY STATE SUITLAND PG MARYLAND									
24 FUNERAL DIRECTOR ALEXANDER S. POPE-2617 Pa Ave SE Wash DC									
25a DATE REC'D BY REGISTRAR OCT 8 1987									
25b REGISTRAR'S SIGNATURE Lincoln Hunt									

100-100 411030

202X 10000 1002

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1. FOR
STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST MIDDLE LAST

Lenora B. Jones

2a DATE OF DEATH MONTH DAY YEAR

Oct. 20, 1987

2b HOUR

3:15 AM

3 SEX

Female

4 RACE

Black

5 DATE OF BIRTH

MONTH DAY YEAR
Jan. 8, 1911

6 AGE (IN YEARS LAST BIRTHDAY)

75

IF UNDER 1 YEAR

MONTHS DAYS HOURS MIN

IF UNDER 12 HRS

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Texas

7b CITIZEN OF WHAT COUNTRY?

USA

8 MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Prince George's MD

10 CITY OR TOWN OF DEATH

Forrestville,

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Regency Nursing Home

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Insurance Agent

12b KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

Maryland

13b COUNTY

Prince George's

13c CITY OR TOWN

Forrestville

13d INSIDE CITY LIMITS? YES ☐ NO ☐

13e STREET ADDRESS / ZIP CODE

1648 Forest Park Drive 20735

14 FATHER'S NAME

William

MIDDLE

B.

LAST

Lott

15 MOTHER'S MAIDEN NAME

Ethel

FIRST

Washington

MIDDLE

Washington

LAST

Washington

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)

no

16b SOCIAL SECURITY NO

398 03 7811

17 INFORMANT

Willard Jones-husband-1648 Forest Park

ADDRESS

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY

Forrestville, Maryland

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a)

CVA

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

YES ☐ NO ☐

20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC)

21f LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a I certify that (1) (this hospital) attended the deceased from 3:20 19 87 to 10:20 19 87 that (1) (we) last saw the deceased alive on 9:27 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (b) (we) (did not) view the body after death.

22b SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c DATE SIGNED

10/20/87

22d PHYSICIAN'S NAME (TYPE OR PRINT)

William K. Furst

22e ADDRESS

11701 Livingston Road, Ft. Washington, Md.

23a BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)

Burial

23b DATE

Oct. 24, 1987

23c NAME OF CEMETERY OR CREMATORY

Maryland National Cem. Laurel, Md.

23d LOCATION

CITY OR TOWN

COUNTY

STATE

24 FUNERAL DIRECTOR

Stewart Funeral Home-4001 Benning Road, N

25a DATE REC'D BY REGISTRAR

NOV 02 1987

25b REGISTRAR'S SIGNATURE

Julia Deider-Randall

070522 NOV-301

REPLY FOLLOW UP

640413

070522 NOV-301

070522 NOV-301

70555 NOV -3 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO 30347

FOR STATE REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DOUGLAS Rennard Joyner

2a DATE KNOWN OF DEATH MONTH DAY YEAR 10/ 27/ 87

2b DATE OF DEATH MATED MONTH DAY YEAR 10/ 29/ 87

3 SEX Male

4 RACE Black

5 DATE OF BIRTH MONTH DAY YEAR June 3, 1956

6 AGE (IN YEARS) LAST BIRTHDAY 31 YRS.

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.

7b CITIZEN OF WHAT COUNTRY? USA

8 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD

10 CITY OR TOWN OF DEATH Temple Hills

11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4112 Murdock St.

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk

12b KIND OF BUSINESS OR INDUSTRY Gov't

13a STATE Maryland

13b COUNTY P.G.

13c CITY OR TOWN Oxon Hill

13d INSIDE CITY LIMITS? YES ☐ NO ☐

13e STREET ADDRESS 1500 South View Drive Apt. 408

14 FATHER'S NAME FIRST MIDDLE LAST Freddie D. Joyner

15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Altheaner Earle

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no

16b SOCIAL SECURITY NO. 214 68 9156

17 INFORMANT ADDRESS Martha Brown-aunt-741 Yuma Street, S.E. Washington, D.C.

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gunshot wound of head
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost
(b)
(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED?

20 AUTOPSY? YES ☒ NO ☐

21a EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 10, 27/ 1987

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) subject shot

21d INJURY OCCURRED WHILE ☐ NOT WHILE ☒ AT WORK ☐ AT WORK

21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) house at

21f LOCATION STREET CITY OR TOWN COUNTY STATE 4112 Murdock St., Temple Hills, Pr. Geo., Md.

22a I certify that I took charge of the remains described above, held on death resulted from Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE Margarita A. Korell, M.D. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 10/30/87

EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn St., Balto., Md. 21201

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

23b DATE Nov 4, 1987

23c NAME OF CEMETERY OR CREMATORY Lincoln Memorial Cemetery Suitland, Maryland

23d LOCATION CITY OR TOWN COUNTY STATE

24 FUNERAL DIRECTOR NAME John I. Stewart

25a DATE REC'D BY REGISTRAR NOV 02 1987

25b REGISTER SIGNATURE Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FORM 18, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 18, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH - 17
(VR A15 ME (1))

20% COTTON FIBER

MADE IN U.S.A.

MADE IN U.S.A.



MADE IN U.S.A.

069067 OCT 20 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 30343

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) WAITE R CHARLES KANTMANN S.R.			2a DATE OF DEATH MONTH DAY YEAR OCT. 12 1987			2b HOUR 12:20P	
3 SEX MALE	4 RACE CAUCASIAN	5 DATE OF BIRTH MONTH DAY YEAR 5-31-07		6 AGE (IN YEARS LAST BIRTHDAY) 80 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE COUNTRY STATE OR FOREIGN KENTUCKY	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES CO. MD			
10 CITY OR TOWN OF DEATH BOWIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12719 KEMBRIDGE DR.			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TOOL & DYE MAKER		12b KIND OF BUSINESS OR INDUSTRY TOOL & DYE	
13a STATE MD		13b COUNTY PG.	13c CITY OR TOWN BOWIE	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 12719 KEMBRIDGE DR. 20715	
14 FATHER'S NAME FIRST MIDDLE LAST ADOLPH GUSTAVE KANTMANN			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CHARLOTTE STUMPFLE				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b SOCIAL SECURITY NO 402-10-1764		17 INFORMANT ADDRESS JANICIE KANTMANN (SAME AS #13)			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of Pancreas DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 8b PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (1) (this hospital) attended the deceased from 8/25 19 86 to 10/12 19 87, that (we) last saw the deceased alive on 10/5/87 19 87 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If two or more I did not write the body after death)							
22b SIGNATURE LEONARD APPEL				DEGREE MD		22c DATE SIGNED 10/12/87	
22e PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS 3231 SUPERIOR LA (AG) Bowie, Md.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE 10-15-1987		23c NAME OF CEMETERY OR CREMATORY ELMWOOD CEMETERY		23d LOCATION CITY OR TOWN COUNTY STATE OWENSBORO, DAVIESS CO., KY.	
24 FUNERAL DIRECTOR NAME W. W. CHAMBERS CO.				ADDRESS RIVERDALE, Md. 20737		25a DATE REC'D BY REGISTRAR OCT 19 1987	
				25b REGISTRAR'S SIGNATURE J. J. Davidson-Randall			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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RECEIVED

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UNIVERSITY OF CALIFORNIA
BERKELEY, CALIF.

068273 OCT 13 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed with 172 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 3 0 3 4 9

FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR				2b HOUR	
FLORA L KAVAKOS						OCTOBER 6. 1987				903 P M	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7b UNDER 1 YEAR		7b UNDER 1 YEAR	
Female		White		MONTH DAY YEAR 7- 10- 1924		63					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		United States				PRINCE GEORGE'S COUNTY MD					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY			
Laurel		GREATER LAUREL BELTSVILLE HOSPITAL				Office Clerk		Private			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b STATE		13c COUNTY		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		14 STREET ADDRESS / ZIP CODE		20705	
Maryland		Prince Ge.		Beltsville				11800 34th Place			
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME								
John T. Thompson			Annie V. Middle Flora								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS					
no		577-26-5590		Louis Kavakos		10010 Hackberry La. Columbia Maryland					
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEPSIS</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>RHEUMATOID ARTHRITIS LATE STAGE</u>											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22 I certify that (1) this hospital attended the deceased from 10/6 to 10/6 1987 that (2) we saw the deceased alive on 10/6 1987 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) we did not view the body after death.											
22b SIGNATURE		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED			
Gregory A. Compton MD								10-6-87			
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS									
Gregory A. Compton MD		8317 Cherry Lane Laurel MD									
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE					
Burial		10-9-1987		Fort Lincoln Cemetery		Brentwood P.G. Maryland					
24 FUNERAL HOME NAME		25a DATE OF BURIAL				25b REGISTRAR'S SIGNATURE					
Donald Borgwardt		4400 Powder Mill Rd. Beltsville, Maryland 20705				OCT 09 1987					

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OCT 09 1981

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1 DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

JOHN

FRANCIS

KENNEDY

2a DATE OF DEATH

MONTH

DAY

YEAR

7b HOUR

OCTOBER 27, 1987

10:20am

3 SEX

Male

4 RACE

Caucasian

5 DATE OF BIRTH

MONTH DAY YEAR
April 23, 1921

6 AGE (IN YEARS LAST BIRTHDAY)

66

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Mass.

7b CITIZEN OF WHAT COUNTRY?

U.S.A.

8 MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Prince George's

MD

10 CITY OR TOWN OF DEATH

Camp Springs

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Malcolm Grow Hospital AAFB

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Pilot

12b KIND OF BUSINESS OR INDUSTRY

US Govt.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE
Maryland

13b COUNTY

P. G.

13c CITY OR TOWN

Camp Springs

13d INSIDE CITY LIMITS? YES ☐ NO ☒

13e STREET ADDRESS / ZIP CODE

4909 Colonial Dr.

20748

14 FATHER'S NAME

Frank

MIDDLE

Kennedy

15 MOTHER'S MAIDEN NAME

Margaret

MIDDLE

Mahoney

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

Yes

16b SOCIAL SECURITY NO

WWII

17 INFORMANT

012-18-8881

ADDRESS

Majorie Kennedy Same as 13 A - E

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) GARDIOPULMONARY ARREST

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) ACUTE MYOCARDIAL INFARCTION

DUE TO, OR AS A CONSEQUENCE OF

(c) CORONARY ARTERY DISEASE

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

YES ☐ NO ☐

20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR

P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)

21f LOCATION STREET

CITY OR TOWN

COUNTY

STATE

22a I certify that ☒ (this hospital) attended the deceased from 27 Oct 19 87 to 27 Oct 19 87 that ☒ (we) last saw the deceased alive on 27 Oct 19 87, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (We/I did) ☒ not view the body after death.

22b SIGNATURE

BRYAN CARDUCCI, MAJ, USAF, MC

DEGREE

ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c DATE SIGNED

27 OCT 87

22d PHYSICIAN'S NAME (TYPE OR PRINT)

22e ADDRESS

MALCOLM GROW USAF MED CEN AAFB, MD 20331

23a BURIAL, CREMATION, REMOVAL (SPECIFY)

Cremation

23b DATE

10/30/87

23c NAME OF CEMETERY OR CREMATORY

Lee's Crematory

23d LOCATION (CITY OR TOWN)

Clinton, Prince George's

MD

24 FUNERAL DIRECTOR NAME

Lee Funeral Home, Inc.

25a DATE REC'D. BY REGISTRAR

OCT 28 1987

25b REGISTRAR'S SIGNATURE

Via Twicken-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The undersigned certifies that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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20% COLIFORM INDEX

10/20/87

070698 NOV 4 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. There please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18, then any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7-84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

FOR 1 - STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT)		FIRST FLORENCE	MIDDLE M.	LAST KIELY	2a DATE OF DEATH MONTH DAY YEAR	2b HOUR
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Sept. 26 1897		6 AGE (IN YEARS LAST BIRTHDAY) 90		7a DATE OF DEATH MONTH DAY YEAR Oct. 31 1987
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Conn.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD		
10 CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Md. Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY own home		
13a STATE Maryland		13b COUNTY Pr. Georges		13c CITY OR TOWN Mitchellsville		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST Timothy McCarthy		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary A. Fennel		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) N/A		17 INFORMANT (son) 10075 Valley Forge Dr. Robert L. Kiely, Sr. Lansdale, PA 19446
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronal Vascular Accident</u>		DUE TO, OR AS A CONSEQUENCE OF (b) <u>Embolic: atherosclerotic plaque</u>		DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronal myocardial infarct</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0								
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from <u>10-29</u> 19 <u>87</u> to <u>10-31</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>10-31</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b SIGNATURE <u>[Signature]</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <u>10-31/87</u>		
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>CRD A. Montonez MD</u>		22e ADDRESS <u>3308 Dodge PK Rd Landover MD</u>						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Nov 4, 1987		23c NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery		23d LOCATION Lansdale Montgomery PA		
24 FUNERAL DIRECTOR NAME Rinaldi Funeral Home		ADDRESS 11800 N.H. Ave., Silver Spring, Md.		25a DATE REC'D. BY REGISTRAR NOV 3 1987		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>		

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

2. DECEASED NAME
(TYPE OR PRINT)

FIRST WILFRED MIDDLE J. LAST KIELY

2a. DATE OF DEATH MONTH DAY YEAR 10 02 87 2b. HOUR 6:45 PM

3 SEX

MALE

4 RACE

White

5 DATE OF BIRTH

MONTH DAY YEAR
June 14, 1912

6 AGE (IN YEARS LAST BIRTHDAY)

75 YRS

7b. UNDER 1 YEAR

7c. UNDER 24 HRS

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

New York

7b. CITIZEN OF WHAT COUNTRY?

United States

8 MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

PRINCE GEORGES MD

10 CITY OR TOWN OF DEATH

CLINTON

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

SOUTHERN MARYLAND HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Salesman

12b. KIND OF BUSINESS OR INDUSTRY

Photography

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Anne Arundel

13c. CITY OR TOWN

Lothian

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE

311 Ella Drive / 20711

14. FATHER'S NAME

FIRST P.

MIDDLE Joseph

LAST Kiely

15 MOTHER'S MAIDEN NAME

FIRST Elizabeth

MIDDLE G.

LAST Dee

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

Yes

16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)

WW II

16c. SOCIAL SECURITY NO

195-07-2352

17 INFORMANT

Jeannette Kiely, Same as 13

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Respiratory failure

DUE TO, OR AS A CONSEQUENCE OF

Septicemia

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

Pneumonia

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.

COPD, Protein calorie malnutrition, Osteoporosis

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M.

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐AT WORK ☐ AT WORK ☐

21e. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22. I certify that (I) (this hospital) attended the deceased from 9/11 1987 to 10/2 1987 that (I) (we) last

saw the deceased alive on 10/2 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

M. Chandra

DEGREE

ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c. DATE SIGNED

10/2/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

M. CHANDRA, M.D.

22e. ADDRESS

9131 Piscataway Road, #710
Clinton, MD 20735

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Cremation

23b. DATE

10-3-87

23c. NAME OF CEMETERY OR CREMATORY

Metropolitan Crematory

23d. LOCATION

CITY OR TOWN

Alexandria, Virginia

COUNTY

STATE

24 FUNERAL DIRECTOR

NAME

Richard Rapp, Inc.

P. O. Box 43352, Washington, DC 20010

25a. DATE REC'D. BY REGISTRAR

OCT 07 1987

25b. REGISTRAR'S SIGNATURE

John R. Rapp

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is (a) any injury, or other traumatic event, the medical examiner must be notified of this.

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OCT 07 1961

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DIVISION OF VITAL RECORDS, 201 W PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Emily Su Kim		2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 18, 1987		2b. HOUR 1745 M	
3. SEX Female		4. RACE Oriental		5. DATE OF BIRTH MONTH DAY YEAR 10 02 1987	
6. AGE (IN YEARS LAST BIRTHDAY) 0 YRS 16 MONTHS 16 DAYS		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Salisbury, Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD		10. CITY OR TOWN OF DEATH Salisbury	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Peninsula General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1405 Toadvine Road 21801			
14. FATHER'S NAME FIRST MIDDLE LAST Man K Kim		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Tok Son			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO 900-18-3187		17. INFORMANT Man K Kim (Father) Same as #13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost } (b) <u>Congenital Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____ that I (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>James J. Reiser</u>		DEGREE M.D.		22c. DATE SIGNED 10-18-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James J. Reiser		22e. ADDRESS 207A Maryland Avenue Salisbury, Md. 21801		22f. MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 10/19/1987		23c. NAME OF CEMETERY OR CREMATORY Salisbury Crematory	
23d. LOCATION (CITY OR TOWN) COUNTY STATE Salisbury, Wicomico, Maryland		24. FUNERAL DIRECTOR Holloway Funeral Home, P.A., Salisbury, Maryland			
25a. DATE REC'D. BY REGISTRAR OCT 21 1987		25b. REGISTRAR'S SIGNATURE <u>Richard R. Rouse</u>			

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NOV-587
FOR
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

67 30354

REG NO

1 DECEASED NAME (TYPE OR PRINT) Joseph GIBBONS King			2a DATE OF DEATH MONTH DAY YEAR 10 / 28 / 87		2b HOUR 11²⁰ A.M.
3 SEX Male	4 RACE Can.	5 DATE OF BIRTH MONTH DAY YEAR Sept. 15, 1918		6 AGE (IN YEARS LAST BIRTHDAY) 69	7b HOUR 11²⁰ A.M.
7a BIRTHPLACE (COUNTRY) Washington D.C.	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD	
10 CITY OR TOWN OF DEATH Greenbelt	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greenbelt Nursing Home		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter		12b KIND OF BUSINESS OR INDUSTRY Construction Co.
13a STATE Wash. D.C.		13b COUNTY Wash. DC	13c CITY OR TOWN Wash. DC	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Lee Davis King		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nettie Gibbons			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW-2	17 INFORMANT 7734 Wash. Blvd., Lot 51, Rixey C. King, Baltimore, Md. 21227		
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Septic DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Urinary tract infection DUE TO, OR AS A CONSEQUENCE OF (c) 1 day					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Severe Congestive heart failure, chronic obstructive pulmonary disease					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN FULL IN PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (1) (this hospital) attended the deceased from 9/24 19 87 to 10/28 19 87 that (1) (we) last saw the deceased alive on 10/24 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did not view the body after death.					
22b SIGNATURE D. Granite MD		DEGREE		22c DATE SIGNED 10/28/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) D. Granite, MD		22e ADDRESS 115 Centerway Greenbelt, MD 20770			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10-31-87	23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Suitland, P.G., Maryland
24 FRANCIS GASCH'S SONS FUNERAL HOME, P.A. NOV 4 1987 4739 Baltimore Ave., Hyattsville, Maryland					

010-28 NOV-261

25-18-19

100% COTTON

10
1 FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DECEASED NAME

FIRST

MIDDLE

LAST

(TYPE OR PRINT)

IRA

CECIL

KITTS

2a DATE OF DEATH

MONTH

DAY

YEAR

2b HOUR

10. 9. 87

3.46 AM

3 SEX

Male

4 RACE

Caucasian

5 DATE OF BIRTH

MONTH

DAY

YEAR

June 19, 1915

6 AGE (IN YEARS LAST BIRTHDAY)

72 YRS

IF UNDER 1 YEAR

MONTHS

DAYS

HOURS

MIN.

7a BIRTHPLACE

(STATE OR FOREIGN COUNTRY)

Virginia

7b CITIZEN OF WHAT COUNTRY?

U.S.A.

MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Prince Georges

MD

10 CITY OR TOWN OF DEATH

Clinton

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Southern Maryland Hospital

12a USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE)
Cook

12b KIND OF BUSINESS OR INDUSTRY

Restaurant

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

Maryland

13b COUNTY

Prince Georges Oxon Hill

13c CITY OR TOWN

13d INSIDE CITY LIMITS?

YES ☐ NO ☒

13e STREET ADDRESS / ZIP CODE

4801 Wheeler Hills Rd. 20745

14 FATHER'S NAME

FIRST

William

MIDDLE

Thomas

LAST

Kitts

15 MOTHER'S MAIDEN NAME

FIRST

Cynthia

MIDDLE

Elizabeth

LAST

Tibbs

16a WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)
Yes

(IF YES, GIVE WAR OR DATES)

W.W. II

16b SOCIAL SECURITY NO.

579-14-6441

17 INFORMANT

Zettie R. Kitts Oxon Hill, MD. 20745

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I: DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Cardiac arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Severe Congestive Cardiac failure

DUE TO, OR AS A CONSEQUENCE OF

(c) Coronary artery disease

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

Peripheral vascular disease

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

YES ☐ NO ☒

20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)

21d INJURY OCCURRED

WHILE ☐ NOT WHILE ☐AT WORK ☐ AT WORK ☐

21e PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a I certify that (I) (this hospital) attended the deceased from 10-8-87, 19, to 19, that I (we) last

saw the deceased alive on 10-8-87, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

above, (I) (we) (did) (did not) view the body after death

22b SIGNATURE

M. D.

DEGREE

M.D.

ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c DATE SIGNED

10/9/87

22d PHYSICIAN'S NAME (TYPE OR PRINT)

MOTI L KOUL M.D.

22e ADDRESS

3710, Rivers St. Temple Hills, Md 20740

23a BURIAL, CREMATION, REMOVAL

(SPECIFY)

Burial

23b DATE

10/12/87

23c NAME OF CEMETERY OR CREMATORY

Union Cemetery

23d LOCATION

CITY OR TOWN

Leesburg

COUNTY

Loudoun

STATE

Virginia

24 FUNERAL DIRECTOR

NAME

Barry J. Brown

Leesburg, Va. 22075

Colonial Funeral Home of Leesburg

25a DATE REC'D. BY REGISTRAR

OCT 19 1987

25b REGISTRAR'S SIGNATURE

John Swickard-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 4 should be detached for use on the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. (IMPORTANT: If item 21 is marked as true, a copy of this certificate must be retained by the medical examiner.)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (PRINT) George M. Kline, Jr.			2a. DATE OF DEATH MONTH DAY YEAR 10/5/87		2b. HOUR 11 34 AM	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 12 14 1929		6 AGE (IN YEARS LAST BIRTHDAY) 57 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD
10 CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital Ctr.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Police Officer		12b. KIND OF BUSINESS OR INDUSTRY D.C. Police
13a. STATE Maryland		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Oxon Hill		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST George M. Kline, Sr.		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Vadah Phillips		13e. STREET ADDRESS / ZIP CODE 1410 Dunwoody Ave/ 20745		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO 229-32-8099		17 INFORMANT Rebecca T. Kline as in item 13		
18 CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Cardiac pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) <u>Massive M.I.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Dr. Note Mellitus</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE Sept 6 19 79 Oct 5 19 87		
22a. I certify that (1) this hospital attended the deceased from <u>Sept 6</u> 19 <u>79</u> to <u>Oct 5</u> 19 <u>87</u> that (2) <u>two</u> last saw the deceased alive on <u>Oct 5</u> 19 <u>87</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (If <u>any</u> that did not view the body after death						
22b. SIGNATURE <u>[Signature]</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen T. Ong M.D.		22e. ADDRESS 6357 Oxon Hill Rd. Oxon Hill, Md. 20745				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-7-87		23c. NAME OF CEMETERY OR CREMATORY Nat'l. Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church Fairfax Va.
24 FUNERAL DIRECTOR NAME G.P. Kalas F.H.		ADDRESS 6160 Oxon Hill Rd. Oxon Hill, Md.		25a. DATE REC'D. BY REGISTRAR OCT 07 1987		
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

RECEIVED
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

187-251 OCT-9-01

RECEIVED
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.



OCT 07 1901

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (PLEASE PRINT) John Jouett KLINE			2a DATE OF DEATH MONTH DAY YEAR October 14, 1987		2b HOUR 8:12p M
3 SEX MALE	4 RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR NOVEMBER 19, 1927		6 AGE (IN YEARS LAST BIRTHDAY) 59 YRS	7 FINDER YEAR 1987
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, DC	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD	
10 CITY OR TOWN OF DEATH Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PRINTER	12b KIND OF BUSINESS OR INDUSTRY GOV'T PRINTING	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MARYLAND			13b COUNTY PR GEORGES	13c CITY OR TOWN COLLEGE PARK	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST JOSEPH N. KLINE			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GERTRUDE DUFFE		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 1945-46		17 INFORMANT ADDRESS SHIRLEY KLINE/WIFE/SAME AS 13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Right Broncho pleural Fistula</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Bronchogenic Carcinoma of T. B. System</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION 10-6-87		19b CONDITION FOR WHICH OPERATION WAS PERFORMED Broncho pleural Fistula		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) P.M. 19		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 8, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>May</u> 19 <u>87</u> to <u>10-14</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>10-14</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <u>Bahram Erfan M.D.</u>		DEGREE <u>M.D.</u>		22c DATE SIGNED	
22b PHYSICIAN'S NAME (TYPE OR PRINT) Bahram Erfan M.D.		22e ADDRESS 6510 Kenilworth Ave., Riverdale, Md. 20737			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE OCT19,1987	23c NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY	23d LOCATION CITY OR TOWN COUNTY STATE ROCKVILLE MONTGOMERY MARYLAND	
24 FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901			25a DATE REC'D. BY REGISTRAR OCT 22 1987		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completed and filed by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or retention.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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OCT 31 81

071050 NOV-68

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1. DECEASED NAME (Type or Print) Doris C. Knott			2a. DATE OF DEATH MONTH DAY YEAR 10 - 28 - 1987		2b. HOUR 4:15 P M
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 7-27-1897		6. AGE (IN YEARS LAST BIRTHDAY) 90	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD	
10. CITY OR TOWN OF DEATH Mitchellville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Villa Rosa Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Drug Store
13a. STATE Maryland		13b. COUNTY P. G.	13c. CITY OR TOWN Mitchellville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Edward D. Chase		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie R. Young		13e. STREET ADDRESS / ZIP CODE 3800 Lotsford Vista Rd. 20716	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Arthur J. Knott Rt 2 Box 518A Mechanicsville, Md 20659	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>URO SEPSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ARTERIOSCLEROTIC HEART DISEASE</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u> <u>10 DAYS</u> <u>15 YEARS</u>
--	--	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in item 1b, Part 1, or Part 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <u>8-2-</u> 19 <u>85</u> to <u>10-28</u> 19 <u>87</u> that (I) last saw the deceased alive on <u>10-7-</u> 19 <u>87</u> and that in (my) own opinion death occurred on the date and hour and from the causes stated above; (I) was (did) not view the body after death.			
22b. SIGNATURE <u>John Cosma M.D.</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>10-28-87</u>
22d. PHYSICIAN'S NAME (Type or Print) <u>JOHN COSMA, M.D.</u>		22e. ADDRESS <u>14300 GALLANT FOX, BOWIE MD. 20715</u>	

23a. BURIAL, CREMATION, REMOVAL (Type or Print) Burial	23b. DATE 10/31/87	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION City or Town Suitland Prince George's Md.
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc. 16633 Old Alexander Ferry Rd Clinton, Md 20735		25a. DATE REC'D. BY REGISTRAR NOV 04 1987	25b. REGISTRAR'S SIGNATURE <u>Julia Deiden-Randall</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, this certificate must be filed at the Division of Vital Records.

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JOHN COLEMAN, MD
ON AMBROS INHOS

OFFICE OF THE ATTORNEY GENERAL
STATE OF ALABAMA

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 30359

1- FOR
STATE
REGISTRAR

REG. NO.

DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
IRVIN			Gustav KOCH			10 19 81				3:25 AM	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR		8 IF UNDER 1 YEAR	
MALE		WHITE		09 24 28		59 YRS					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				Prince George's County MD					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. OF HOUSE OR RADIATOR			
RIVERDALE, MD.		LELAND MEM. HOS.				Owner					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
Maryland		P.G.		Hyattsville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4015 Madison Street 20781			
14 FATHER'S NAME FIRST MIDDLE LAST				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
William Gustav Koch				Pauline Marie Graefe							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17 INFORMANT							
Yes-Army		Korean		213-24-3460		William Koch (Son) Hyattsville, Md. 20781					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <i>Cardiac arrest with respiratory arrest.</i>										minutes	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Acute hypoxia due to aspiration and airway obstruction</i>										minutes	
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cancer of the larynx</i>										weeks	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
<i>Chronic obstructive pulmonary disease Hypertension</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 2b. PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED (HOME <input type="checkbox"/> NOT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION (STREET CITY OR TOWN COUNTY STATE)							
22a. I certify that (1) <i>this hospital</i> attended the deceased from <i>September 19 87</i> to <i>October 19 87</i> that (1) <i>was</i> last saw the deceased alive on <i>September 19 87</i> and that in my <i>own</i> opinion death occurred on the date and hour and from the causes stated above, (2) <i>did not</i> view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
<i>Byrl D. Johnson</i>				MD				10/19/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
BYRL D. JOHNSON				4404 Queensbury Rd. Riverdale, Md 20737							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN COUNTY STATE)					
Burial		10/23/87		Fort Lincoln Cemetery Brentwood		P.G. Maryland					
25a. DATE REC'D. BY REGISTRAR						25b. REGISTRAR'S SIGNATURE					
OCT 26 1987						<i>John D. Johnson</i>					

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069805 OCT 27 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT FRANCIS KOHLER			2a DATE OF DEATH MONTH DAY YEAR OCTOBER 19 1987		2b HOUR 8:40A M
3 SEX Male	4 RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Nov. 20, 1943		6 AGE (IN YEARS LAST BIRTHDAY) 44 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Henderson, Nevada	7b CITIZEN OF WHAT COUNTRY? United States	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD	
10 CITY OR TOWN OF DEATH LANHAM	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DOCTORS' HOSPITAL OF PR. GEO. CO.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant	12b KIND OF BUSINESS OR INDUSTRY V.A.	
13a STATE Maryland			13b COUNTY Pr. Georges	13c CITY OR TOWN Lanham	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST Frank Joseph Kohler			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ada Lois McGinnis		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 553-60-4404		17 INFORMANT ADDRESS Lanham, MD 20706 7235-Oliver Street	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Possible Aids</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerosis, Coronary Heart Disease</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Slow</i> <i>3-4 weeks</i> <i>2 years</i>
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I

MEDICAL CERTIFICATION

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I, IF PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <i>10-16-1987</i> to <i>10-19-1987</i> that (I) (we) last saw the deceased alive on <i>10-19-1987</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b SIGNATURE <i>[Signature]</i>	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED <i>10/19/87</i>
22d PHYSICIAN'S NAME (TYPE OR PRINT) Ohannes Sahakian, M.D.		22e ADDRESS 5632 Annapolis Rd Bladensburg, Md. 20710	

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b DATE Oct. 20, 1987	23c NAME OF CEMETERY OR CREMATORY Lee's Crematory	23d LOCATION (CITY OR TOWN COUNTY STATE) Washington, District of Columbia
24 FUNERAL DIRECTOR NAME J. Wm. Lee's Sons Co. 300-4th St., NE, Wash., DC 20002		25 DATE RECEIVED BY REGISTRAR OCT 25 1987	

DHMH 16 60M 7/84
(VRA 15. 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal. It must be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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SECRET

CONFIDENTIAL

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070402 NOV-2-87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3036

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Louise Koon			2a DATE OF DEATH MONTH DAY YEAR 10 26 87		2b HOUR 4:58 pm	
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR July 14, 1909		
6 AGE (IN YEARS (LAST BIRTHDAY)) 78		7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b CITIZEN OF WHAT COUNTRY? U.S.A.		
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges		MD		
10 CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital Center		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		
12b KIND OF BUSINESS OR INDUSTRY N/A		13a STREET ADDRESS / ZIP CODE 1409 Fenwood Avenue 20745				
13b STATE Maryland		13c COUNTY Prince George		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST Harvey Jasper Williamson		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Agnes Pearson				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 220-05-2240		17 INFORMANT ADDRESS Sterling J. Koon Oxon Hill, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c) Mitral and Aortic Valvular Stenosis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6/20 19 80		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 5b, PART 3 OR PART 2)		
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE		
22a I certify that (I) (as a hospital) attended the deceased from 6/20 19 80 to 10/26 87 that (I) (w) saw the deceased alive on Oct. 26th, 1987 and that in (my) (or) opinion death occurred on the date and hour and from the causes stated above, (I) (as a doctor) did not view the body after death.						
22b SIGNATURE <i>Victor S. Chupkovich</i>		DEGREE		22c DATE SIGNED Oct. 27/1987		
22d PHYSICIAN'S NAME (TYPE OR PRINT) Victor S. Chupkovich M.D.		22e ADDRESS 9131 Piscataway Rd. Clinton, Md. 20735				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10/31/87		23c NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		
23d LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland						
24 FUNERAL DIRECTOR NAME ADDRESS G.P. Kalas F.H. 6160 Oxon Hill Rd. Oxon Hill, Md.		25a DATE REC'D. BY REGISTRAR OCT 30 1987		25b REGISTRAR'S SIGNATURE <i>Julia...</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										30302	
FOR 1- STATE REGISTRAR										REG. NO.	
DECEASED NAME (TYPE OR PRINT) Ellamar J. Knight										7a DATE KNOWN OF DEATH ESTIMATED 10-16-87	
7b HOUR M										7c DATE PRONOUNCED DEAD 10-16-87	
7d HOUR 253										7e HOUR M	
3 SEX Female										4 RACE BLACK	
5 DATE OF BIRTH MONTH 3 DAY 2 YEAR 17										6 AGE (IN YEARS) LAST BIRTHDAY 70 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. CAROLINA										7b CITIZEN OF WHAT COUNTRY? U.S.A.	
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9 BALTIMORE CITY OR COUNTY OF DEATH P.E. Co.	
10 CITY OR TOWN OF DEATH CAMP SPRINGS										11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANDREWS A.E.B. Hospital	
12a USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE D.C. 13b COUNTY Wash. 13c CITY OR TOWN Wash.										13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET ADDRESS 7301- Blair Rd N.W. D.C.										17a USUAL OCCUPATION (TYPE OF WORK) PRERSSER	
17b KIND OF BUSINESS OR INDUSTRY DRY CLEANER										17c	
14 FATHER'S NAME FIRST SESS MIDDLE SWINSON LAST SWINSON										15 MOTHER'S MAIDEN NAME FIRST LOUVENIA MIDDLE (UNKNOWN) LAST (UNKNOWN)	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) N/A										16b SOCIAL SECURITY NO. UNKNOWN	
17 INFORMANT Daughter ADDRESS 3830 PINEY BRANCH RD. SS. MD										18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE Intervascular embolism under atheroma DUE TO, OR AS A CONSEQUENCE OF disease DUE TO, OR AS A CONSEQUENCE OF (c)	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a DATE OF OPERATION										19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)										21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	
21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .										22b	
ACTUAL SIGNATURE Augusto P. Rodriguez M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER										DATE SIGNED 10-16-87	
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D. ADDRESS 5009 Rayburn Ct, Temple Hills, MD											
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL										23b DATE 10-24-87	
23c NAME OF CEMETERY OR CREMATORY HARMONY Cemetery										23d LOCATION CITY OR TOWN LANDOVER P.G.C. MD COUNTY STATE	
24 FUNERAL DIRECTOR NAME MODERN FUNERAL HOME ADDRESS 3821-14th ST. MD D.C.										25a DATE RECD. BY REGISTRAR OCT 27 1987	
25b REGISTRAR'S SIGNATURE Julia Borden-Rodriguez											

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1- FOR STATE REGISTRAR					REG. NO.					
1 DECEASED NAME (TYPE OR PRINT) LORRAINE MATILDA KYRISS					2a DATE OF DEATH MONTH DAY YEAR OCT 13 1987					2b HOUR 3:40A M
3 SEX FEmale		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR January 18 1925		6 AGE (IN YEARS LAST BIRTHDAY) 62 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		8 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Hortense Texas		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George MD				
10 CITY OR TOWN OF DEATH Andrews AFB, Md		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Malcolm Grow Medical Center				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY Own home		
13a STATE Maryland		13b COUNTY Pr George		13c CITY OR TOWN Upper Marlboro		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 12108 Northwood Drive 20772		
14 FATHER'S NAME FIRST MIDDLE LAST Horace Handley		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maybelle Whitehead		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b SOCIAL SECURITY NO 466-32-0169		17 INFORMANT Harold A. Kyriess	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>METASTATIC SQUAMOUS CELL CARCINOMA OF PHARYNX</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>UNDEFINED NEUROLOGIC EVENT</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE						
22a I certify that (this hospital) attended the deceased from 12 OCT 19 87 to 13 OCT 19 87, that (we) last saw the deceased alive on 13 OCT 19 87, and that in (our) opinion death occurred on the date and hour and from the causes stated above (we) did (not) view the body after death										
22b SIGNATURE <i>[Signature]</i>					DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 13 OCT 87	
22d PHYSICIAN'S <i>[Signature]</i>					22e MALCOLM GROW USAF MED CTR (MAC) ANDREWS AFB, WASHINGTON, D.C. 20331					
23a BURIAL, CREMATION, REMAINS (SPECIFY) Burial		23b NAME OF CEMETERY OR CREMATORY Fagen Cemetery			23c LOCATION CITY OR TOWN COUNTY STATE Polk County Texas		23d DATE REC'D BY REGISTRAR OCT 19 1987			
24 FUNERAL DIRECTOR NAME Robert E Wilhelm Funeral Home					25a DATE REC'D BY REGISTRAR OCT 19 1987					
25b REGISTRAR'S SIGNATURE <i>[Signature]</i>										

BP

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200-20-2000 FILE 0000
ONE MORE FILE
JOHN I. CORPORA

69135 OCT 20 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Emery Dal Lamaster, Jr.			2a DATE OF DEATH MONTH DAY YEAR Oct. 11, 1987		2b HOUR 5:01 P.M.	
1 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR Jan 20, 1931		
7a BIRTHPLACE (STATE OR FOREIGN) West Virginia		7b CITIZEN OF WHAT COUNTRY? US		6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 56		
10 CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hosp.		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD		
12a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12b STATE Md.		12c COUNTY Howard		12d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13a FATHER'S NAME FIRST MIDDLE LAST Emery Dal Lamaster, Sr.		13b MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth (unknown)		13c CITY OR TOWN Elkridge		
15a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) n/a		15b SOCIAL SECURITY NO. 235-42-7083		17 INFORMANT ADDRESS Virginia Lamaster same as 13e		
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (b) Pulmonary Edema and Pneumonitis DUE TO, OR AS A CONSEQUENCE OF UNDERLYING CAUSE LAST (c) Anasarca, Malnutrition						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Gangrene Feet, Due to Atherosclerosis Generalized						
19a DATE OF OPERATION 10/7/87		19b CONDITION FOR WHICH OPERATION WAS PERFORMED Gangrene Feet		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21f OR PART 2) 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.) 21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from 9/30 19 87 to 10/11 19 87 that (I) (we) last saw the deceased alive on 10/11 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.						
22b SIGNATURE Wm. A. Holbrook M.D.		DEGREE M.D.		22c DATE SIGNED 10/12/87		
22d PHYSICIAN'S NAME (TYPE OR PRINT) Wm. A. Holbrook M.D.		22e ADDRESS 5901 Medical Terrace, Cheverly, Md 20835				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10/14/87		23c NAME OF CEMETERY OR CREMATORY Md. Nat'l Memo. Pk.		
23d LOCATION Laurel P.G. Md.		23e DATE RECEIVED BY REGISTRAR OCT 19 1987				
24 FUNERAL DIRECTOR NAME Fleck Funeral Home, Inc.		ADDRESS 7601 Sandy Spring Rd. Laurel, Md. 20707		REGISTRAR'S SIGNATURE Julia Davidson-Randall		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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071243 NOV-9 1987

OR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Tillie Mindel Lamasure			2a DATE OF DEATH MONTH DAY YEAR October 30, 1987		2b HOUR 4:35 P.M.
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR September 4, 1914		6 AGE (IN YEARS (LAST BIRTHDAY)) 73 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE Washington, D.C.	7b CITIZEN OF WHAT COUNTRY? U. S. A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD		
10 CITY OR TOWN OF DEATH Beltsville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12900 Craiglawn Court		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Resident Manager	12b KIND OF BUSINESS OR INDUSTRY Apartments	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland		13b COUNTY P. G.	13c CITY OR TOWN Beltsville	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 12900 Craiglawn Court 20705
14 FATHER'S NAME Abraham		15 MOTHER'S MAIDEN NAME Annie		MIDDLE Allsfine	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 579-40-1869		17 INFORMANT ADDRESS Edwin M. Lamasure (Same as # 13)	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) METASTATIC CARCINOMA, UNKNOWN PRIMARY SITE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (b) stating the underlying cause lost (c) _____ DUE TO, OR AS A CONSEQUENCE OF					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 mos
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)	
21d INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (1) (the hospital) attended the deceased from July 14, 1987 to October 30, 1987 that (1) (we) last saw the deceased alive on October 16, 1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) view the body after death.					
22b SIGNATURE James A. Brown				22c DATE SIGNED 10/31/1987	
22d PHYSICIAN'S NAME (TYPE OR PRINT) James A. Brown, M. D.				22e ADDRESS 14801 Physicians Lane, # 271, Rockville, Md.	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 11/1/1987		23c NAME OF CEMETERY OR CREMATORY Mount Lebanon	
23d LOCATION Hyattsville, P. G. Md.		23e NAME OF CEMETERY OR CREMATORY Hyattsville, P. G. Md.			
DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.				25a DATE REC'D BY REGISTRAR NOV 04 1987	
				25b REGISTRAR'S SIGNATURE John Davidson-Randall	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please forward this certificate, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

BP _____

The following information was obtained from the records of the
 Department of the Interior, Bureau of Land Management, on
 November 12, 1968, regarding the land owned by the
 United States in the State of California.
 The total area of land owned by the United States in
 California is approximately 100,000,000 acres.
 The land is owned by the United States in several
 different capacities, including as follows:
 1. Land owned by the United States in fee simple.
 2. Land owned by the United States in trust for the
 benefit of the people of the State of California.
 3. Land owned by the United States in trust for the
 benefit of the people of the United States.
 4. Land owned by the United States in trust for the
 benefit of the people of the world.
 The land owned by the United States in fee simple is
 approximately 10,000,000 acres. The land owned by the
 United States in trust for the benefit of the people of
 the State of California is approximately 50,000,000
 acres. The land owned by the United States in trust for
 the benefit of the people of the United States is
 approximately 20,000,000 acres. The land owned by the
 United States in trust for the benefit of the people of
 the world is approximately 20,000,000 acres.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 0 0 0 0

071129 NOV-987

1- STATE DECEASED NAME (TYPE OR PRINT)		FIRST <i>Carl</i>		MIDDLE <i>Joseph</i>		LAST <i>LaNore Jr</i>		2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR <i>Oct 31 1987</i>		2b. HOUR M <i>11:45</i>	
3 SEX <i>M</i>	4 RACE <i>W</i>	5 DATE OF BIRTH MONTH DAY YEAR <i>June 17 1867</i>	6 AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS HOURS MIN <i>19 YRS</i>	IF UNDER 1 YR	IF UNDER 24 HRS	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <i>Oct 31 1987</i>		7d. HOUR M <i>11:45</i>		7e. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges MD</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Michigan</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges MD</i>		10 CITY OR TOWN OF DEATH <i>Laurel</i>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Computer Systems Operator U.S. Govt.</i>	
12 USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a STATE <i>MD</i>		12b COUNTY <i>Prince Georges</i>		12c CITY OR TOWN <i>Riverdale</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <i>6314 61st Pl</i>		13f ZIP CODE <i>20737</i>	
14 FATHER'S NAME FIRST MIDDLE LAST <i>Louis LaNore</i>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Behr</i>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>		16b SOCIAL SECURITY NO. <i>381-16-0914-A</i>		17 INFORMANT <i>Cecilia LaNore (Wife) Riverdale, Md. 20737</i>		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Dis.</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i>Chronic Obstructive Pul. Dis.</i> DUE TO, OR AS A CONSEQUENCE OF (c)	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I : <i>None</i>											
19a DATE OF OPERATION <i>None</i>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 8B PART I OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>John S. Rogers</i>		TITLE (SPECIFY) <i>Dep.</i>		MEDICAL EXAMINER		DATE SIGNED <i>Oct 31 1987</i>					
EXAMINER'S NAME (TYPE OR PRINT) <i>John S. Rogers, M.D.</i>		ADDRESS <i>1919 Seminary Rd. Silver Spring, Md.</i>									
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b DATE <i>11/04/87</i>		23c NAME OF CEMETERY OR CREMATORY <i>Maryland Veterans Cem.</i>		23d LOCATION CITY OR TOWN COUNTY STATE <i>Cheltenham P.G. Maryland</i>					
24 FUNERAL DIRECTOR NAME <i>Francis Gasch's Sons Funeral Home, P.A.</i>		25a DATE REC'D BY REGISTRAR <i>NOV 06 1987</i>		25b REGISTRAR'S SIGNATURE <i>Frederick R. ...</i>							
25c REGISTRAR'S SIGNATURE <i>Frederick R. ...</i>											

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM 10-1, RETAINING COPIES FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, PAGE 1 AND 2 SHOULD BE KEPT WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

Dear Sir,
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the above mentioned matter.

I am sorry to hear that you are having trouble with your machine. I will be glad to send you a new one if you wish. I will also send you a new one if you wish.

I am, Sir, very respectfully,
Your obedient servant,
J. H. [Signature]

70557 NOV-387

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO.

30367

DECEASED NAME (TYPE OR PRINT)		FIRST <i>Gloma</i>		MIDDLE		LAST <i>Lawrence</i>		7a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <i>10-16 1987</i>		7b. HOUR M	
3 SEX <i>Female</i>		4 RACE <i>Black</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>2-8-36</i>		6 AGE (IN YEARS) (LAST BIRTHDAY) <i>51</i> YRS.		IF UNDER 1 YR MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD <i>10-16 1987</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Washington, D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Prince George's</i> MD					
10 CITY OR TOWN OF DEATH <i>Suitland</i>		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Andrews AFB Malcolm Grove</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Teacher D.C. Public School</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <i>Maryland</i>		13b. COUNTY <i>P.G.</i>		13c. CITY OR TOWN <i>Forestville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>2723 Lorrington Drive</i>			
14 FATHER'S NAME FIRST MIDDLE LAST <i>Esco Lawrence</i>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Edith Ham</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>578 56 2284</i>		17 INFORMANT ADDRESS <i>Avey Lawrence-son-4724 Huron Ave., Suitland, Maryland</i>							
18 CAUSE OF DEATH (Enter only one cause of death for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE <i>Hypertensive cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>				TITLE (SPECIFY) <i>Deputy</i> MEDICAL EXAMINER				DATE SIGNED <i>10-17-87</i>			
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez, M.D.</i>				ADDRESS <i>5009 Rayburn Ct., Temple Hills, MD</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Oct. 23, 1987</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lincoln Memorial Cemetery</i>				23d. LOCATION CITY OR TOWN COUNTY STATE <i>Suitland, Md.</i>			
24 FUNERAL DIRECTOR (NAME) <i>Stewart Funeral Home</i>				25a. DATE REC'D. BY REGISTRAR <i>NOV. 02 1987</i>				25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD., 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07-B4
25M

BP

DHMH - 17
(VR A15 ME (1))

705221 WCV-301

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10-12-52

068328 00

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										30368	
1- FOR STATE REGISTRAR										REG NO	
2a DECEASED NAME FIRST MIDDLE LAST Madeline C. Lawrence										2b DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 10/5 19 87	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Mar. 17, 1936		6 AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN 51 YRS		IF UNDER 1 YR IF UNDER 24 HRS		7c DATE PRONOUNCED DEAD MONTH DAY YEAR 10/5 19 87	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's County			7d HOUR P. M. 7:37 P.		
10 CITY OR TOWN OF DEATH Bowie		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12606 Chanlee Lane				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK		12b KIND OF BUSINESS OR INDUSTRY US GOV'T			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a STATE Maryland		13b COUNTY Prince George's		13c CITY OR TOWN Bowie		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 12606 Chanlee Lane		20715	
14 FATHER'S NAME FIRST MIDDLE LAST William J. Feehley				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Madsen							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b SOCIAL SECURITY NO. 213 26 8451		17 INFORMANT ADDRESS Dalton B. Lawrence, Husband, Same as #13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last } (b) carcinoma of the lung. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos.											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a None											
19a DATE OF OPERATION None				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH None				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) None					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>John S. Rogers</i>				TITLE (SPECIFY) Deputy				DATE SIGNED 10/6/87			
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.				ADDRESS 1919 Seminary Road Silver Spring, Montgomery County, MD							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b DATE Oct. 6, 1987		23c NAME OF CEMETERY OR CREMATORY Chambers Crematory		23d LOCATION CITY OR TOWN COUNTY STATE Riverdale, P.G. Co., MD			
24 FUNERAL DIRECTOR NAME W.W.CHAMBERS CO., INC.,				ADDRESS 8655 Georgia Avenue		25a DATE REC'D. BY REGISTRAR OCT 09 1987		25b REGISTRAR'S NAME <i>Davidson</i>			

7-84
25M

BP

DHMH - 17
(VR A15 ME (5))

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Madeline C. Lawrence

10/5 10/5

White Box 12, 1975

Female

15000 Chamlee Lane

Box 12

15000 Chamlee Lane

Montgomery Prince George's Box 12

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0.000

None

None

None

X

X

10/5 10/5

1975 January 1975

11/10/75 Prince George's County, MD

John S. Horner, M.D.

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68132 OCT -9

07- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Nettie May LEAMAN			2a DATE OF DEATH October 2, 1987			2b HOUR 10:35p ^M			
3 SEX Female		4 RACE Caucasion		5 DATE OF BIRTH 8 MONTH 10 DAY 07 YEAR		6 AGE (IN YEARS LAST BIRTHDAY) 80		7 UNDER 1 YEAR YRS	
7a BIRTHPLACE (STATE OR FOREIGN) Virginia		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD			
10 CITY OR TOWN OF DEATH Lanham		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AMI Doctors' Hosp. of Pr. Geo. Co.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY Own Home	
13a STATE Maryland		13b COUNTY Pr. Geor.		13c CITY OR TOWN Riverdale		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 4808 Tuckerman St. 20737	
14 FATHER'S NAME FIRST MIDDLE LAST Franklin Monroe Sampson			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nettie P. Utz			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No N/A			
16b SOCIAL SECURITY NO. 218-38-7802			17 INFORMANT Betty Matthias			ADDRESS 2035 Richard RD. Willow Grove, PA 19090			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>METASTATIC MALIGNANT LYMPHOMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21b PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>8-31-1987</u> to <u>10-2-1987</u> , that (I) (we) last saw the deceased alive on <u>8-31-1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <u>Sankaran M. Nayar</u>						DEGREE MD		22c DATE SIGNED 10-3-87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) SANKARAN M. NAYAR, MD						22e ADDRESS 3717 38 th AVE BREWWOOD, MD 20722			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 10-6-87		23c NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery Brentwood P. Geor. Maryland		23d LOCATION CITY OR TOWN COUNTY STATE		
24 FUNERAL DIRECTOR NAME Francis Gasch's Sons P.A.			4739 Baltimore Ave. Hyattsville, Md.			25a DATE REC'D BY REGISTRAR 8-15-87		25b REGISTRAR'S SIGNATURE	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

January

February

3

100-130 801080

100-130 801080

100-130 801080

100-130 801080

070502 NOV

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

30370
20 DATE KNOWN OF DEATH ☒ MONTH ☐ DAY ☐ YEAR
OCT 22, 1987
Btw 4:30

1- FOR STATE REGISTRAR
DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Michael Darryl Lee

3 SEX Male 4 RACE Black 5 DATE OF BIRTH MONTH DAY YEAR
June 22, 1971 6 AGE (IN YEARS) (LAST BIRTHDAY) 16 YRS.
IF UNDER 1 YR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C. 7b CITIZEN OF WHAT COUNTRY? United States
8 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD

10 CITY OR TOWN OF DEATH Suitland 11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
4657 Bromley Avenue
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) High School Student/Suitland
12b KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE Maryland 13b COUNTY Prince Georges 13c CITY OR TOWN Suitland
13d INSIDE CITY LIMITS? YES ☒ NO ☐ 13e STREET ADDRESS High School
4657 Bromley Avenue (20746)

14 FATHER'S NAME FIRST MIDDLE LAST Grier Flemming Lee Sr.
15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Linda Carol Yates

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No 16b SOCIAL SECURITY NO. 579-82-4990
17 INFORMANT ADDRESS 4657 Bromley Avenue, (20746)
Linda Carol Lee (mother) Suitland, Maryland

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Shotgun wound to the head
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last
(b) DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a DATE OF OPERATION 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? 20 AUTOPSY? YES ☐ NO ☒

21a EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH
21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 10-22-87 Self inflicted
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d INJURY OCCURRED WHILE ☐ NOT WHILE ☒ AT WORK ☐ AT WORK
21e PLACE OF INJURY (AT HOME ☒ STREET FACTORY, FARM, ETC.) Home
21f LOCATION CITY OR TOWN COUNTY STATE
4657 Bromley Ave. Suitland P.G. Co. MD

22a I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Augusto P. Rodriguez, M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER
DATE SIGNED 10-22-87

EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D. ADDRESS 5009 Rayburn Ct., Temple Hills, MD

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b DATE Oct. 27, 1987 23c NAME OF CEMETERY OR CREMATORY Washington National
23d LOCATION CITY OR TOWN COUNTY STATE
Suitland, P.G. Co., Maryland

24 FUNERAL DIRECTOR NAME LATNEY's Funeral Home ADDRESS 3831 Georgia Avenue, N.W.; Washington, D.C. 20011
25a DATE REC'D. BY REGISTRAR OCT 30 1987 25b REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

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DHMH-17
(VR A15 ME (15))

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20% COTTON LIME

WINTER

WINTER 1950-51

WINTER 1950-51

069635 OCT 26 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR					
MARY ROSE LEMKE						October 18 1987			12:35pm					
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)					
Female			White			October 10 1902			85 YRS					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH					
Pennsylvania			USA						Prince George's MD					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY		
Lanham			Prince George's Doctor's Hospital						Homemaker			Own Home		
13a STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?			13e STREET ADDRESS / ZIP CODE		
Maryland			Pr George			Seat Pleasant			<input type="checkbox"/> NO <input type="checkbox"/>			6314 Foote Street 20743		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME											
Peter McLaughlin			Isabelle Dwyer											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS					
No						Otto Albert Lemke			Same as #13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiovascular failure</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last														
DUE TO OR AS A CONSEQUENCE OF (b) <u>myocardial infarction</u>														
DUE TO OR AS A CONSEQUENCE OF (c) <u>hypertension</u>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>coronary artery disease, diabetes</u>														
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18B PART 1 OR PART 2)								
			P.M. 19											
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE								
22 I certify that (a) this hospital attended the deceased from <u>10/10</u> 19 <u>87</u> to <u>10/18</u> 19 <u>87</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated														
22b SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED					
<u>Lewis H Dennis</u>									10/18/87					
22d PHYSICIAN'S NAME (TYPE OR PRINT)			22e ADDRESS											
Lewis H Dennis, M.D.			6201 Greenbelt Rd. Greenbelt, Md.											
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION CITY OR TOWN COUNTY STATE					
Burial			21 Oct 1987			Washington National			Suitland PG Md					
24 FUNERAL DIRECTOR NAME			24b ADDRESS			25a DATE REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE					
Robert E Wilhelm			Funeral Home			OCT 23 1987			<u>Davidson</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove cause of death papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked as item 18 show every injury or other traumatic event, the medical examiner must be notified at once.

BP

070039 OCT 28 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) EDYTHE A. LOGAN -Harden			2a DATE OF DEATH MONTH DAY YEAR 10-23-87			2b HOUR 2:25 AM	
3 SEX F	4 RACE Cauc	5 DATE OF BIRTH MONTH DAY YEAR 07 16 04		6 AGE (IN YEARS LAST BIRTHDAY) 83 YRS		7a UNTER 1 YEAR 7b UNTER 23 HRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri	7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George MD		
10 CITY OR TOWN OF DEATH Greenbelt	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greenbelt Nursing Center			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker		12b KIND OF BUSINESS OR INDUSTRY n/a	
13a STATE Maryland				13b COUNTY Prince George		13c CITY OR TOWN Beltsville	
14 FATHER'S NAME William Oscar		15 MOTHER'S MAIDEN NAME Nancy Hamilton		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b SOCIAL SECURITY NO 218-56-3042		17 INFORMANT Sheryl A. Olverson 209 Chambers Ridge 17402					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BREAST CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (b) WITH METASTASIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c)							
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 X							
19a DATE OF OPERATION X		19b CONDITION FOR WHICH OPERATION WAS PERFORMED X		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) X			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input checked="" type="checkbox"/> STREET <input checked="" type="checkbox"/> OFFICE <input type="checkbox"/> FARM ETC.)		21e PLACE OF INJURY X		21f LOCATION STREET CITY OR TOWN COUNTY STATE X			
22a I certify that (I) (this hospital) attended the deceased from 8-25-19-87 to 10-23-19-87 that (I) (we) last saw the deceased alive on 10-23-19-87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did (did not) view the body after death.							
22b SIGNATURE ASIF S. QADRI				DEGREE MD		22c DATE SIGNED 10/23/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) ASIF S. QADRI				22e ADDRESS 4700 BERWYN HOUSE RD, College PK			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10/26/87		23c NAME OF CEMETERY OR CREMATORY George Washington		23d LOCATION CITY OR TOWN COUNTY STATE Adelphi Prince George Md.	
24 FUNERAL DIRECTOR Donald V. Borgwardt 4400 Powder Mill Rd. Beltsville Md 20705				25a DATE REC'D BY REGISTRAR OCT 27 1987		25b REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

29

1

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies (pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000).

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(VRA 15, 4)

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OR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM Leroy LOMAX			2a DATE OF DEATH MONTH DAY YEAR 10 4 87			2b HOUR M 6:15am	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR May 16, 1918		6 AGE (IN YEARS LAST BIRTHDAY) YRS. 69	
7a BIRTHPLACE COUNTRY Washington, D.C.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD	
10 CITY OR TOWN OF DEATH CLINTON MD		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION SOUTHERN MARYLAND HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Administrative	
12b KIND OF BUSINESS OR INDUSTRY U.S. Gov't.		13a INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13b STREET ADDRESS 20747			
14 FATHER'S NAME FIRST MIDDLE LAST Claude Lomax		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Easton		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, STATE WAR OR DATES) yes WWII			
16b SOCIAL SECURITY NO 577-12-1537		17 INFORMANT ADDRESS Wife - Eleanor O. Lomax - Same as #13					

18 CAUSE OF DEATH Enter only one cause per line for a, b, and c. PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cancer of Lungs		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 WK	
DUE TO, OR AS A CONSEQUENCE OF (b) Respiratory failure			
DUE TO, OR AS A CONSEQUENCE OF (c) _____			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last			

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a DATE OF OPERATION N/A		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NAME MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY, LOCATION IN PART 1 OR PART 2)			
21d INJURY OCCURRED (1) WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> (2) WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) this hospital attended the deceased from 9-15 19 87 to 10-4 19 87 that (II) we last saw the deceased alive on 10-4- 19 87 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) we (II) we did (did not) view the body after death.							
22b SIGNATURE C. Wolferum		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10-4-87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) C. Wolferum		22e ADDRESS 7501 Sunnyside Rd. Clinton					

23a BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial		23b DATE Oct. 8, 1987		23c NAME OF CEMETERY OR CREMATORY Md. Vets. Cem.		23d LOCATION CITY OR TOWN COUNTY STATE Cheltingham, Maryland	
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24 FUNERAL DIRECTOR (NAME) James B. B...		DeVol Funeral Home Washington, D.C.		25a DATE REC'D BY REGISTRAR OCT 8 1987		25b REGISTRAR'S SIGNATURE Julia Davidson-Rodgers	
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in the funeral director's office. Page 3 should be detached to be used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

30374

1 DECEASED NAME (TYPE OR PRINT) Beverly R. Luckritz			2a DATE OF DEATH MONTH DAY YEAR 10/22/87			2b HOUR 9:00 pm		
3 SEX F	4 RACE white	5 DATE OF BIRTH MONTH DAY YEAR 6 29 37			6 AGE (IN YEARS LAST BIRTHDAY) 50 YRS			7 UNDER 1 YEAR MONTH DAY YEAR
7a BIRTHPLACE (COUNTRY) Missouri	7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Prince George County MD		
10 CITY OR TOWN OF DEATH Beltsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4307 Briggs Chaney Rd.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) cafeteria asst.		12b KIND OF BUSINESS OR INDUSTRY school system

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland 13b COUNTY Prince George 13c CITY OR TOWN Beltsville				13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 4307 Briggs Chaney Rd. 20705	
14 FATHER'S NAME FIRST MIDDLE LAST Alfred C. Richter			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Melvina Nireman			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO 487-36-8598		17 INFORMANT ADDRESS William Luckritz 4307 Briggs Chaney Rd. 20705		

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic carcinoma</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b) <u>Squamous carcinoma of esophagus</u> 4 years	
(c)			

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM OF PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	

22a I certify that (I) (this hospital) attended the deceased from April 19 73 to Oct 22 19 87 that (I) (we) last saw the deceased alive on Oct 14 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.

22b SIGNATURE <u>Arthur S. Bresler</u>	DEGREE <u>M.D.</u>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED 10-23-87
22d PHYSICIAN'S NAME (TYPE OR PRINT) Arthur S. Bresler		22e ADDRESS 10881 Lockwood Dr. Silver Spring Md 20901	

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 10/27/87	23c NAME OF CEMETERY OR CREMATORY George Washington	23d LOCATION (CITY OR TOWN) COUNTY STATE Adelphi Prince George Md.
24a FUNERAL DIRECTOR Donald V. Borgwardt 4400 Powder Mill Rd. Beltsville Md 20705		25a DATE REC'D. BY REGISTRAR OCT 27 1987	
25b REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO.

1. DECEASED NAME (TYPE OR PRINT) CHIU KAO LUNG			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 15 1987			2b. HOUR 1:45P M				
3. SEX Male		4. RACE Oriental		5. DATE OF BIRTH MONTH DAY YEAR November 15, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS		7. IF SPENDER YEAR SPENDER MONTH SPENDER DAY SPENDER MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Hupei, China		7b. CITIZEN OF WHAT COUNTRY? Nationalist Chinese		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD				
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo Co.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired-Chef		12b. KIND OF BUSINESS OR INDUSTRY Restaurant				
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7515-Alfred Drive 20910	
14. FATHER'S NAME FIRST MIDDLE LAST Chuan Song Lung			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO 577-86-2644		17. INFORMANT ADDRESS Shyue Yeu Long (Son) Same as #13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Chronic Renal Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)			21f. LOCATION CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 19 85 to 10/15/ 19 87 that (I) (we) last saw the deceased alive on 10/15/ 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) witness the body after death.										
22b. SIGNATURE <u>Shyue Yeu Long</u>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ABRAHAM DABELA			22e. ADDRESS 4404 Queensberry Rd Riverdale							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Oct. 18, 1987		23c. NAME OF CEMETERY OR CREMATORY George Washington Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Adelphi, Pr. Georges Co., Maryland			
24. FUNERAL DIRECTOR NAME J. Wm. Lee's Sons Co.			ADDRESS 300-4th St., NE, Wash., DC 20002			25a. DATE REC'D. BY REGISTRAR OCT 22 1987		25b. REGISTRAR'S SIGNATURE John Gordon		

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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080205 OCT 23 81

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21c is marked on item 18, show any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1 - FOR STATE REGISTRAR					REG. NO.					
2a DECEASED NAME (TYPE OR PRINT) LAWRENCE MACKALL					2b DATE OF DEATH MONTH DAY YEAR 10-24-87					
3 SEX MALE		4 RACE BLACK		5 DATE OF BIRTH MONTH DAY YEAR Dec. 19, 1901		6 AGE (IN YEARS LAST BIRTHDAY) 85 YRS		7b HOUR 9 : 00AM		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD				
10 CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES HOSPITAL CENTER				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b KIND OF BUSINESS OR INDUSTRY		
13a STATE Maryland					13b COUNTY Prince Geo.		13c CITY OR TOWN Seat Pleasant		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Joseph Mackall					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosie Brooks					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO -		17 INFORMANT ADDRESS Joseph Mackall Apt. #404 Dares Beach Rd.						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>COPD, SIPMI, HTN, old left CVA.</u>										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION (CITY OR TOWN, COUNTY, STATE)						
22a I certify that (this hospital) attended the deceased from <u>Oct 23 87</u> to <u>Oct 24 87</u> that I (we) last saw the deceased alive on <u>Oct 23 87</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If not, I (we) did not view the body after death.)										
22b SIGNATURE <u>Stuart Turkowitz, MD</u>				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10/24/87				
22d PHYSICIAN'S NAME (TYPE OR PRINT) Stuart Turkowitz, MD				22e ADDRESS 7500 Greenway Center Dr. Greenbelt, MD-20770						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Oct. 31, 1987		23c NAME OF CEMETERY OR CREMATORY Patuxent Chr. Cem.		23d LOCATION (CITY OR TOWN, COUNTY) Huntingtown Calvert MD				
24 FUNERAL DIRECTOR NAME Spencer E. Sewell				1451 Dares Beach Rd. Prince Frederick, MD 20678		25a DATE REC'D BY REGISTRAR NOV 5 1987		25b REGISTRAR'S SIGNATURE <u>London R. Randa</u>		

068587 OCT 14 '87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

30377
REG NO

1 DECEASED NAME (TYPE OR PRINT) JAMES P MALACH			2a DATE OF DEATH MONTH DAY YEAR 10 2 87		2b HOUR 4:35pm
3 SEX M	4 RACE W	5 DATE OF BIRTH MONTH DAY YEAR 10 7 45	6 AGE (IN YEARS LAST BIRTHDAY) 41 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENN.	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD		
10 CITY OR TOWN OF DEATH CLINTON MD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BARBER	12b KIND OF BUSINESS OR INDUSTRY	
13a STATE MD.		13b COUNTY PRINCE GEO.	13c CITY OR TOWN CLINTON	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST UNK.		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNK.			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO 176-36-9967		17 INFORMANT ADDRESS MEDICAL RECORDS - CLINTON CONVALES- CENT CNTR. 899-4566	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cecilio pulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Brain edema Brain Tumour</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Status Epilepticus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE PARK, ETC.) CH		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>9-11-87</u> to <u>10-2-87</u> that (I) (we) last saw the deceased alive on <u>10-2-87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <u>[Signature]</u>		DEGREE MD		22c DATE SIGNED 10-3-87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) ABULHASAN ANSARI		22e ADDRESS 8926 Woodland Rd #101 Clinton Md. 20735			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b DATE 10-5-87	23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE
24 FUNERAL DIRECTOR NAME State Anatomy Board		ADDRESS Balto., Md.		25a DATE REC'D BY REGISTRAR OCT 09 1987	25b REGISTRAR'S SIGNATURE <u>[Signature]</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

1. The first part of the report
 describes the general situation
 of the country and the
 progress of the work.

2. The second part of the report
 describes the results of the
 work and the progress of the
 work.

3. The third part of the report
 describes the results of the
 work and the progress of the
 work.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME FIRST MIDDLE LAST Hazel Melba Marks			2a. DATE OF DEATH MONTH DAY YEAR October 21, 1987		2b. HOUR 7:00 a.m.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 4, 1903		
7a. BIRTHPLACE (COUNTRY) Washington D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS) LAST BIRTHDAY 84 YRS.		
10. CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5110 42nd Avenue		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD		
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Hyattsville		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5110 42nd Avenue 20781				
14. FATHER'S NAME FIRST MIDDLE LAST William Franklin Wilson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE Etta Phillips				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578-26-4866		17. INFORMANT Carl A. Marks (Son) Hyattsville, Md. 20781		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Stand-Still -</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) <u>Brain Atrophy, Alzheimer's Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertensive Cardio Vascular Disease</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 0 3 yrs 6 yrs	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 OR PART 1)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE		
22a. I certify that (1) [this hospital] attended the deceased from <u>6/30/81</u> , 19____, to <u>10/21/87</u> , 19____, that (1) [we] last saw the deceased alive on <u>10/9/87</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) [we] (do) (did not) view the body after death.						
22b. SIGNATURE <u>Gordon W. Kelley M.D.</u>		DEGREE <u>M.D.</u>		22c. DATE SIGNED <u>10/21/87</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Gordon W. Kelley, M.D.		22e. ADDRESS 6124 41st Avenue Hyattsville, Md. 20782				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/24/87		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland						
25a. DATE REC'D. BY REGISTRAR NOV 04 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>				

MEDICAL CERTIFICATION

070041 NOV-200

Q70864 NOV-587

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST PEGGY Sharon MARSHALL			2a. DATE OF DEATH MONTH DAY YEAR 10-28-87		2b. HOUR 8 30PM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 23, 1929		6. AGE (IN YEARS, LAST BIRTHDAY) 58 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD	
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGE'S HOSPITAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland				13b. COUNTY P.G.		13c. CITY OR TOWN Bladensburg	
14. FATHER'S NAME FIRST MIDDLE LAST Leonard Larrich				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Viola Kirby			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-36-3117		17. INFORMANT (Husband) ADDRESS Samuel Robert Marshall Bladensburg, Md. 5534 Volta Avenue			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Diabetes Mellitus Complication of heart</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic renal infection</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20710
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 1987</u> to <u>Oct 1987</u> that (I) (we) last saw the deceased alive on <u>Sept 1987</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Robert J. Casch</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ROBERT J. CASCH</u>				22e. ADDRESS <u>4410 74th Ave Landover Hills Md 20785</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/02/87		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland	
24. FUNERAL DIRECTOR Francis Casch's Sons Funeral Home, P.A.				25a. DATE REC'D. BY REGISTRAR NOV 4 1987			
4739 Baltimore Avenue Hyattsville, Md. 20781				25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Pandora</u>			

DHMH - 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the event.

17-00000-1

COLLECTION

17-00000-1

NOV 4 1983

070674 NOV 4 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1. FOR STATE REGISTRAR		2. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7a. DATE OF DEATH MONTH DAY YEAR		7b. HOUR	
		EUPHIA R MAXWELL		FEMALE		BLACK		10 12 21		55 YRS		10 27 87		10 35AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
North Carolina		U.S.				PRINCE GEORGES'								MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
CHEVERLY		PRINCE GEORGE'S HOSPITAL CENTER		Housewife		None									
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE							
Maryland		PG		Capital Hghts.				1004 Balboa Avenue						20747	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME													
Daniel Henry Bethune		Liza McMillan													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17. INFORMANT											
No		245-62-3010		Euphia M. Washington		3329 Walters Lane #103									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		PART 1: DEATH WAS CAUSED BY													
		IMMEDIATE CAUSE (a)		CARDIOVASCULAR ARREST											
		DUE TO, OR AS A CONSEQUENCE OF		ACUTE MYOCARDIAL INFARCTION											
		DUE TO, OR AS A CONSEQUENCE OF		DIABETES MELLITUS											
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1		RENAL INSUFFICIENCY													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 2 OR PART 3)											
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION											
22a. I certify that (I) (this hospital) attended the deceased from 10/14/87 to 10/27/87 that (I) (we) last saw the deceased alive on 10/27/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS													
ARVIND M. MEHTA		7100 BALTIMORE AVE, COLLEGE PARK													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION									
Burial		10-31-87		Washington National		Suitland PG Maryland									
24. FUNERAL DIRECTOR		25. REGISTRATION BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Robert G. Mason		1661 Good Hope Road, S.E.		NOV 03 1987		Julia Gordon-Randall									

050074 NOV-4-65

070517 NOV-287

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EUFEMIA B. MAZARIEGOS			2a DATE OF DEATH MONTH DAY YEAR OCTOBER 24, 1987		2b HOUR 8:00 A.M.
3 SEX FEMALE	4 RACE WHITE	5 DATE OF BIRTH MONTH DAY YEAR MARCH 19, 1926	6 AGE (IN YEARS LAST BIRTHDAY) YEARS MONTHS DAYS 61		IF UNDER 1 YEAR HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) GUATEMALA	7b CITIZEN OF WHAT COUNTRY? GUATEMALA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD		
10 CITY OR TOWN OF DEATH LANHAM	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9002 2ND STREET		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER	12b KIND OF BUSINESS OR INDUSTRY HOME	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MARYLAND			13b COUNTY P.G. CO.	13c CITY OR TOWN LANHAM	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST MIGUEL - MAZARIEGOS			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ALICIA - MALDONADO		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 218-06-6120	17 INFORMANT ADDRESS JOVINTA LYNCH (DAUGHTER) SAME AS #13.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC GALLBLADDER CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (the hospital) attended the deceased from 10-23 1987 to 10-24 1987 that (I) (we) last saw the deceased alive on 10-24 1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) (did not) view the body after death.					
22b SIGNATURE Michele Fox M.D.		DEGREE M.D.		22c DATE SIGNED OCT. 24, 1987	
22d PHYSICIAN'S NAME (TYPE OR PRINT) MICHELE FOX, M.D.		22e ADDRESS GEORGETOWN UNIVERSITY HOSPITAL - WASHINGTON, D.C.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b DATE OCT/26/87	23c NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY	23d LOCATION CITY OR TOWN COUNTY STATE ROCKVILLE, MONT. CO., MARYLAND		
24 FUNERAL DIRECTOR NAME W.W. CHAMBERS CO., INC.		ADDRESS 5801 CLEVELAND AVE. RIVERDALE, MD		25a DATE REC'D. BY REGISTRAR OCT 30 1987	25b REGISTRAR'S SIGNATURE Julia...

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the other papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

BP

070217 NOV-581

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [Illegible]
[The following text is mirrored and largely illegible due to bleed-through from the reverse side of the page. It appears to be a memorandum or report detailing an investigation or administrative matter.]

169323 OCT 22 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JAMES McARDLE			2a. DATE OF DEATH MONTH DAY YEAR OCT. 19, 1987		2b. HOUR 6:45 A.M.			
3. SEX MALE		4. RACE CAUC		5. DATE OF BIRTH MONTH DAY YEAR 8 11 14		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SCOTLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE MD.		
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1135 LINDEN AVENUE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STONE MASON BLDG SUPERVISOR		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MARYLAND			13b. COUNTY PRINCE GEO		13c. CITY OR TOWN TAKOMA PARK		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN McARDLE			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BRIDGET CAMPBELL		13e. STREET ADDRESS / ZIP CODE 1135 Linden Ave. Takoma Pk, MD 20912			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO 577-50-7951		17. INFORMANT JOSEPHINE McARDLE - 1135 LINDEN AVE T.P.			ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchogenic Carcinoma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) COPD, Noninsulin dependent diabetes								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18b PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from 9-24 19 87 to 10-19 19 87 that (1) (we) last saw the deceased alive above; (2) (I) (did not) view the body after death; and that in my (our) opinion death occurred on the date and hour and from the causes stated								
22b. SIGNATURE John Kijak, Jr., M.D.				DEGREE MD		22c. DATE SIGNED 10-19-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS 12520 Prosperity Drive Silver Spring, MD 20904				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct 22, 1987		23c. NAME OF CEMETERY OR CREMATORY Gate Of Heaven Cemetery Silver Spring		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring MD		
24. FUNERAL DIRECTOR NAME Takoma Funeral Home		ADDRESS 254 Carroll Rd NW DC		25a. DATE RECD. BY REGISTRAR OCT 20 1987				

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Kathleen Louise McCormack			7a DATE OF DEATH MONTH DAY YEAR 10 - 01 - 1987			7b HOUR 1:30 ^A M				
3 SEX Female		4 RACE Caucasian XX		5 DATE OF BIRTH MONTH DAY YEAR 9 19 1898		6 AGE (IN YEARS LAST BIRTHDAY) 89		8 IF UNDER 1 YEAR IF UNDER 72 HRS YRS MONTHS DAYS HRS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George MD				
10 CITY OR TOWN OF DEATH Mitchellville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Villa Rosa Nursing Home			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b KIND OF BUSINESS OR INDUSTRY U.S. Govt.			
13a STATE Florida			13b COUNTY Margate		13c CITY OR TOWN Margate		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 6610 N. W. 29th Street 33063	
14 FATHER'S NAME FIRST MIDDLE LAST John B. Crisfield			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kathryn Gallagher			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO - - - -			16b SOCIAL SECURITY NO. 263-78-6014	
17 INFORMANT Carryl P. Frank			ADDRESS 2609 Kinway Lane Bowie, Maryland 20715							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Aneurysm</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral aneurysm</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT IF UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from <u>11-29-82</u> to <u>10-1-87</u> , that (I) (we) last saw the deceased alive on <u>9-30-87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE <u>[Signature]</u>			DEGREE <u>MD</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10-1-87		
22d PHYSICIAN'S NAME (TYPE OR PRINT) EIPD A. MONTAGNE MD			22e ADDRESS 8308 Dodge PK Rd Bethesda MD							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Removal/Burial			23b DATE OCT 5, 1987		23c NAME OF CEMETERY OR CREMATORY Lauderdale Mem. Park		23d LOCATION CITY OR TOWN COUNTY STATE Ft. Lauderdale, Florida			
24 FUNERAL DIRECTOR NAME Scott F. [Signature]			ADDRESS 16000 [Signature] Road Bowie MD			25a DATE REC'D BY REGISTRAR OCT 7 1987		25b REGISTRAR'S SIGNATURE [Signature]		

067300-01-001

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

1- DECEASED NAME FIRST MIDDLE LAST MARGUERITE MCCORMICK		2a DATE OF DEATH MONTH DAY YEAR October 27, 1987		2b HOUR A. 6:50 M
3 SEX Female	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR Nov. 10, 1900		6 AGE (IN YEARS LAST BIRTHDAY) 86
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD
10 CITY OR TOWN OF DEATH Hyattsville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Home, Inc.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b KIND OF BUSINESS OR INDUSTRY Home
13a STATE Md.		13b COUNTY P.G.	13c CITY OR TOWN Temple Hills	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST John R. Ridgely		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Estella Seltzer		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) n/a	16b SOCIAL SECURITY NO. 215-46-3512	17 INFORMANT ADDRESS William F. McCormick same as 13e		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a Arteriosclerotic Heart disease, Hypertension				
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART I OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from 7/10/85 to 10/27/87 that (I) (we) last saw the deceased alive on 10/24/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.				
22b SIGNATURE J. M. Khatr		DEGREE MD	22c DATE SIGNED 10/27/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) I. M. KHATRI		22e ADDRESS 6525 Belcrest Rd., #902 Hyattsville MD		
23a BURIAL, CREMATION, REMOVAL (15) Burial	23b DATE 10/31/87	23c NAME OF CEMETERY OR CREMATORY St. Mary's Cem.	23d LOCATION Laurel	P.G. Maryland
24 FUNERAL DIRECTOR 7601 Sandy Spring Road Fleck Funeral Home, Inc. Laurel, Md. 20707		25a DATE REC'D BY REGISTRAR OCT 30 1987		
25b REGISTRAR'S SIGNATURE Julia Gordon-Parker				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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OCT 30 1958

Black International House, Inc. 30707

1801 Sandy Bottom Road

W/2/97 St. Mary's Cam.

Serial

I M KAY 1

B. H. K.

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10/2/58

Aluminum Co. of Am.

Aluminum Co. of Am.

W/2/97 St. Mary's Cam.

W/2/97 St. Mary's Cam.

W/2/97 St. Mary's Cam.

W/2/97 St. Mary's Cam.

W/2/97 St. Mary's Cam.

W/2/97 St. Mary's Cam.

W/2/97 St. Mary's Cam.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.	
1- FOR STATE REGISTRAR		2a DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Irene Pearl McGraw</i>						2b DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <i>10-24-87</i>		2c HOUR <i>10-24-87</i>			
3 SEX <i>Female</i>	4 RACE <i>Caucasian</i>	5 DATE OF BIRTH MONTH DAY YEAR <i>June 2, 1890</i>	6 AGE (IN YEARS LAST BIRTHDAY) <i>97 YRS.</i>	7 IF UNDER 1 YR MONTHS DAYS	8 UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD <i>10-24-87</i>		2d HOUR <i>10-24-87</i>		2e HOUR <i>10-24-87</i>			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Washington, D.C.</i>		7b CITIZEN OF WHAT COUNTRY? <i>United States</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Prince George's county, MD</i>							
10 CITY OR TOWN OF DEATH <i>Lanham</i>		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Drs. Hospital of Prince George's Co.</i>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>					
13a STATE <i>N</i>		13b COUNTY <i>N</i>		13c CITY OR TOWN <i>Washington, D.C.</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <i>3905 Windom Place, N.W. 20016</i>					
14 FATHER'S NAME FIRST MIDDLE LAST <i>Robert MacDonald</i>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Delia Quailey</i>									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>		16b SOCIAL SECURITY NO. <i>578-01-0167</i>		17 INFORMANT <i>Robert H. McCray</i>				ADDRESS <i>same as #13</i>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Anterior cluster coronary artery disease</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a <i>Chronic obstructive pulmonary disease</i>													
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH P.M. 19				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>				TITLE (SPECIFY) <i>Deputy</i>				DATE SIGNED <i>10-26-87</i>					
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez, M.D.</i>				ADDRESS <i>5009 Rayburn Ct, Temple Hills, MD</i>									
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b DATE <i>Oct. 27, 1987</i>		23c NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cemetery</i>				23d LOCATION CITY OR TOWN COUNTY STATE <i>Washington, D.C.</i>			
24 FUNERAL DIRECTOR <i>Robert A. Pumphrey Funeral Home/ Bethesda-Chesley Chase, Inc. 7557 Wisconsin Ave. Bethesda, Maryland 20814</i>				25a DATE REC'D BY REGISTRAR <i>OCT 27 1987</i>				25b REGISTRAR'S SIGNATURE <i>John D. ...</i>					

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069846 OCT 27 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
FOR 1- STATE REGISTRAR									
REG. NO.									
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Fern G McDonald			2a DATE OF DEATH MONTH DAY YEAR 10 17 87			2b HOUR 9 ²⁵ AM			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 04 21 07		6 AGE (IN YEARS LAST BIRTHDAY) 80 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Indiana		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD			
10 CITY OR TOWN OF DEATH Riversdale		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Zeland Memorial Hospital				12a USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Book Keeper		12b KIND OF BUSINESS OR INDUSTRY GMC Truck Sales	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a STATE Maryland		13b COUNTY P.G.		13c CITY OR TOWN Hyattsville		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 4707 66th Avenue 20784	
14 FATHER'S NAME FIRST MIDDLE LAST Oder Gregg			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Bogan			ADDRESS 4707 66th Avenue Hyattsville, Md. 20784			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 314-05-2080		17 INFORMANT Patricia Ann Smith (Daughter)					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Coronary H. Disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Hypertension									
MEDICAL CERTIFICATION									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from 10-12-1987 to 10-12-1987 that I (we) last saw the deceased alive on 10-12-1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) did not view the body after death.									
22b SIGNATURE Dr. S. T. Chanchian O. H. S. SAKIAN						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10.18.87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) O. H. S. SAKIAN				22e ADDRESS 5632 Annapolis Bl. Beltsville					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10/22/87		23c NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Lebanon Boone Indiana		23e FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781	
23f DATE REC'D. BY REGISTRAR OCT 26 1987				23g REGISTRAR'S SIGNATURE					

00000000000000000000

From Mr. [illegible]

To Mr. [illegible]

For [illegible]

By [illegible]

At [illegible]

This [illegible]

Witness my hand and seal

at [illegible]

this [illegible]

day of [illegible]

19[illegible]

Notary Public

for the State of [illegible]

My commission expires [illegible]

Subscribed and sworn to before me

at [illegible]

this [illegible]

100023 OCT 28 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 30387

1. FOR STATE REGISTRAR		REG. NO.	
1 DECEASED NAME (TYPE OR PRINT)		2a DATE OF DEATH MONTH DAY YEAR	
FIRST MIDDLE LAST JOSEPH JOHN MCGUIRE		OCT 22 1987	
3 SEX		2b HOUR	
Male		6:45a.m.	
4 RACE		6 AGE (IN YEARS LAST BIRTHDAY)	
White		82 YRS	
5 DATE OF BIRTH MONTH DAY YEAR		7a BALTIMORE CITY OR COUNTY OF DEATH	
10 22 05		Prince George's MD	
7b BIRTHPLACE (STATE OR FOREIGN COUNTRY)		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
Wash., D. C.		U. S. A.	
9 CITY OR TOWN OF DEATH		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Andrews A.F.B.		Retired Lt.	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12b KIND OF BUSINESS OR INDUSTRY	
Malcolm Grow Med. Center		U.S. Navy	
13a STATE		13b COUNTY	
Maryland		Charles	
13c CITY OR TOWN		13d INSIDE CITY LIMITS?	
Newburg		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> XX	
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	
William James Mc Guire		Mary T. Flaherty	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.	
Yes		1922-1952	
17 INFORMANT ADDRESS		17b BALTIMORE CITY OR COUNTY OF DEATH	
Sharon Royer, Newburg, Md.		20664	
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)			
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u>			
DUE TO, OR AS A CONSEQUENCE OF			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
(b) <u>PROBABLE PNEUMONIA</u>			
DUE TO, OR AS A CONSEQUENCE OF			
(c) <u>PULMONARY EMBOLUS</u>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1			
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR	
		P.M. 19	
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 OR PART 2)		21d LOCATION CITY OR TOWN COUNTY STATE	
22a I certify that <input checked="" type="checkbox"/> this hospital attended the deceased from <u>04 SEPT</u> 19 <u>87</u> to <u>22 OCT</u> 19 <u>87</u> that <input checked="" type="checkbox"/> we last saw the deceased alive on <u>22 OCT</u> 19 <u>87</u> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)			
22b SIGNATURE		22c DATE SIGNED	
<i>Frank J. Archer</i> M.D.		22 OCT 87	
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS	
FRANK J. ARCHER, CAPT, USAF MC		MALCOLM GROW USAF MED CEN, ANDREWS AFB MD	
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE	
Burial		10/26/87	
23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE	
Md. Vets. Cemetery		Cheltenham, P.G., Md.	
24 FUNERAL DIRECTOR NAME		25a DATE REC'D. BY REGISTRAR	
Arehart Funeral Home, Inc., La Plata, Md.		OCT 27 1987	
25b REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon copies. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

70-82-100-85-0-0

1. *Journal of Management Studies*, 1996, 33, 1, 1-14.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

070160 OCT 29 87

FOR
1- STATE
REGISTRAR

REG. NO.

1- DECEASED NAME (TYPE OR PRINT) AnnaBelle E McIntire			2a. DATE OF DEATH October 25 1987			7b. HOUR 2:20 P ^M		
3 SEX Female	4 RACE White	5. DATE OF BIRTH Feb 5 1924	6 AGE (IN YEARS LAST BIRTHDAY) 63			8 UNDER 1 YEAR MONTHS DAYS		9 UNDER 74 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN) Washington DC		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George MD		
10 CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's Hospital			12a. USUAL OCCUPATION (TYPE OF WORK OR DUTIES OF WORKING, IF E) clerk		12b. KIND OF BUSINESS OR INDUSTRY US Gov't	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Pr Geo 13c. CITY OR TOWN Capitol Hgt			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 5022 Eno Street 20743		
14 FATHER'S NAME Charles Edelin			15 MOTHER'S MAIDEN NAME Catherine					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NAME UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO 578 20 9893		17 INFORMANT Bruce Edward McIntire Same as #13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Small Cell Carcinoma of Lung</u> DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (If) <u>Chronic Obstructive Lung Disease</u>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN REMARKS OF PART 3 OR PART 5)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (IF HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION CITY OR TOWN COUNTY STATE		
22a. I certify that I (the Registrar) attended the deceased from <u>10/18/87</u> to <u>10/18/87</u> that I last saw the deceased alive on <u>10/18/87</u> and that in my opinion death occurred on the date and hour and from the causes stated above. If I did not view the body after death.								
22b. SIGNATURE <u>L. V. Kaufman</u>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>10/26/87</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Louis V. Kaufman			22e. ADDRESS 8926 Woodyard Rd Clinton Md 20736					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 28 Oct 1987		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION Suitland Maryland	
24 FUNERAL DIRECTOR'S NAME Robert E Wilhelm			24b. ADDRESS 4308 Suitland Rd Suitland Md			25. DATE REC'D BY REGISTRAR OCT 28 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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030 100 000 000

070400 NOV-2887

FOR
TAS
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) George Franklin McKay, Jr.			2a. DATE OF DEATH MONTH DAY YEAR 10 27 87			2b. HOUR 2:36AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2 10 1914		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD			
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctor Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Superintendent		12b. KIND OF BUSINESS OR INDUSTRY Cemeteries			
13a. STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Lothian		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Waysons Mobile Ct. Lot 71 20711	
14. FATHER'S NAME FIRST MIDDLE LAST George F. McKay, Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Blanche Clements						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO 212- 18-3848		17. INFORMANT ADDRESS Margaret L. McKay as in item 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF, (b) <u>hypertension</u> Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause last <u>subarachnoid hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF, (c) <u>subarachnoid hemorrhage</u>									
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>emphysema</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF OTHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from 10/26/87 to 10/27/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated.									
22b. SIGNATURE <u>Lewis H. Dennis</u>				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/27/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis H. Dennis, M.D.				22e. ADDRESS 6201 Greenbelt Rd., College Park, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-29-87		23c. NAME OF CEMETERY OR CREMATORY Washington Nat'l. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. Md.			
24. FUNERAL DIRECTOR NAME ADDRESS G.P. Kalas 6160 Oxon Hill Rd. Oxon Hill, Md.				25a. DATE REC'D. BY REGISTRAR OCT 30 1987		25b. REGISTRAR'S SIGNATURE <u>James Davidson</u>			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

07-04-00 101-581

067802 OCT

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Catherine A. McKee			2a. DATE OF DEATH MONTH DAY YEAR 10 1 87		2b. HOUR 8:56 P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 4 16 1933		6. AGE (IN YEARS LAST BIRTHDAY) 54	IF UNDER 1 YEAR MONTH DAY HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD	
10. CITY OR TOWN OF DEATH CLINTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home
13a. STATE Md.		13b. COUNTY Pr. George	13c. CITY OR TOWN Oxon Hill	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Albert Nutwell		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Simpson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 577-42-5406		17. INFORMANT ADDRESS Laurence A. McKee as in item 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Atherosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cellular Vascular Disease</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour 10 years 5 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Chronic Lung Disease</u>					
19a. DATE OF OPERATION 9/25/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Trauma to Ankle		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN REMARKS, PART 3, OR PART 4)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9/25 1987 to 10/1 1987 that (I) (we) last saw the deceased alive on 10/1 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did not view the body after death.					
22b. SIGNATURE Jonathan M. Adelson, M.D.		DEGREE M.D.		22c. DATE SIGNED 10/2/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jonathan M. Adelson, M.D.		22e. ADDRESS 7801 Old Branch Ave., Clinton, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-5-87	23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Clinton P.G. Md.
24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home		6160 Oxon Hill Rd. Oxon Hill, Md.		25a. DATE REC'D BY REGISTRAR OCT 05 1987	
25b. REGISTRAR'S SIGNATURE John J. Anderson-Randall					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7-84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 2 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

3039

1. DECEASED-NAME (Type or print) HENRY JOSEPH. McKENNA.			2a. DATE OF DEATH Month 10 Day 5 Year 1987			2b. HOUR 3:40 P.M.			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH May 11, 1908		6. AGE (In years last birthday) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's County, Md.			
10. CITY OR TOWN OF DEATH Bowie		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 2908 Stonybrook Dr.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Interior Decorator		12b. KIND OF BUSINESS OR INDUSTRY Retail			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN Bowie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2908 Stonybrook Drive/20715	
14. FATHER'S NAME First Middle Last Henry McKenna			15. MOTHER'S MAIDEN NAME First Middle Last Louise Toscano						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 051-03-0117		17. INFORMANT Address Catherine L. Stascavage, Same as # 13.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST. DUE TO, OR AS A CONSEQUENCE OF (b) VENTRICULAR TACHYCARDIA DUE TO, OR AS A CONSEQUENCE OF (c) CONGESTIVE HEART FAILURE.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 MONTHS 1 MONTH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) METASTATIC CARCINOMA OF PROSTATE									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 5/19 , 19 87 , to 10/5 , 19 87 , that (I) (we) last saw the deceased alive on 10/3 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Roberto A. Depetris MD				DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 10/5/87.	
22d. PHYSICIAN'S NAME (Type) ROBERTO A. Depetris MD				22e. ADDRESS 14300 GALLANT FOX LA #122 BOWIE Md 20715					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE Oct. 6, 1987		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION (City or Town) (County) (State) Alexandria, Fairfax, Virginia			
24. FUNERAL DIRECTOR Beall Funeral Home				16000 Annapolis Rd. Bowie, Maryland 20817		25a. REC'D BY REGISTRAR OCT 7 1987		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 12 hours after death.

007070 001-801

RECEIVED IN THE
OFFICE OF THE
DIRECTOR

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [illegible]
DATE: 10-1-57
RE: [illegible]

[The following text is extremely faint and largely illegible, appearing to be a multi-paragraph memorandum or report. It contains several lines of text, some of which may be headers or subject lines, but the specific content cannot be accurately transcribed.]

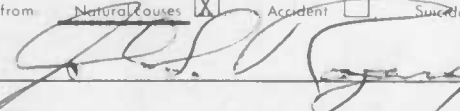

069335 OCT 22 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

30392

FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Agnes Eloise McKenzie			2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 10/19 19 87			2b. HOUR P:40		
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR Sep. 21, 1922	6 AGE (IN YEARS) (LAST BIRTHDAY) 64 YRS	IF UNDER 1 YR MONTHS DATE HOURS MIN	IF UNDER 24 HRS	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10/19 19 87	2d. HOUR P:40	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD		
10 CITY OR TOWN OF DEATH Bowie		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12412 Stretton Lane				12a. USUAL OCCUPATION (TYPE OF WORK) FOR MOST OF WORKING LIFE Beautician		12b. KIND OF BUSINESS OR INDUSTRY Retail
13a. STATE Maryland			13b. COUNTY Prince George's		13c. CITY OR TOWN Bowie	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST William Corry Smith			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mattie Lee Owens			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		
16b. SOCIAL SECURITY NO. 264-26-9461			17 INFORMANT ADDRESS Mary E. Garrison 6901 Raw Hide Ridge Columbia, MD 21040			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myocardial disease. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) None								
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from <u>Natural Causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE 			TITLE (SPECIFY) Deputy MEDICAL EXAMINER			DATE SIGNED 10/20/87		
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.			ADDRESS 1919 Seminary Road Silver Spring, Montgomery County, MD					
23a. BURIAL, CREMATION, REMOVAL (TYPE, BY) Burial			23b. DATE OCT 22, 1987			23c. NAME OF CEMETERY OR CREMATORY Ft. Linclon Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Pr. George's, MD			24 FUNERAL DIRECTOR NAME ADDRESS Beall Funeral Home 16000 Annapolis Road Bowie, MD 20715-3043			25a. DATE REC'D. BY REGISTRAR OCT 21 1987		
25b. REGISTRAR'S SIGNATURE 								

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

x

10/19/87

McAnis

John

James

6/10

10/19/87

Female White Oct. 17, 1987 6/10

Prince George's County

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168987 OCT 20 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Melvin Hill McLEAN SR.			2a. DATE OF DEATH October 10, 1987		2b. HOUR 6:45a M
3. SEX Male	4. RACE White	5. DATE OF BIRTH Nov. 17, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS	7. UNDER 1 YEAR 8. UNDER 2 1/2 HRS
7a. BIRTHPLACE (STATE OR FOREIGN) District of Columbia	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's Co. MD.	
10. CITY OR TOWN OF DEATH Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AMI Doctors' Hosp. or Pr. Geo. Co.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Construction Co. Executive	12b. KIND OF BUSINESS OR INDUSTRY Own Business	
13a. STATE Maryland	13b. COUNTY Pr. Geo's	13c. CITY OR TOWN Upper Marlboro	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 9210 Columbine Lane/20772	
14. FATHER'S NAME FIRST MIDDLE LAST Walter -- McLean		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice --- Mayhew			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No ----		16b. SOCIAL SECURITY NO		17. INFORMANT Jean McLean-Upper Marlboro, Md. 20772	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>coronary atherosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF, (b) <i>coronary artery disease</i> DUE TO, OR AS A CONSEQUENCE OF, (c) <i>arteriosclerosis</i> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a) STATING THE UNDERLYING CAUSE LAST					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>diabetes mellitus</i> (b) <i>hypertensive disorder</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF OTHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 10		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART I OR PART II)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WORK <input type="checkbox"/> <input type="checkbox"/> ALL OTHERS <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from <i>10/13/87</i> to <i>10/16/87</i> and that (2) my opinion of death occurred on the date and hour and from the causes stated above (1) (a) (b) (c) did not occur after death.					
22b. SIGNATURE <i>Lewis H. Dennis</i>		DEGREE M.D.		22c. DATE SIGNED <i>10/12/87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis H. Dennis, M.D.		22e. ADDRESS 831 University Blvd., E. Silver Spring, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10/13/87	23c. NAME OF CEMETERY OR CREMATORY Washington Nat'l Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Suitland (Pr. Geo's) Md.		
24. FUNERAL DIRECTOR Richard A. Coleman - Upper Marlboro, Md. 20772 Funeral Home		25a. DATE REC'D. BY REGISTRAR 10-9-1987			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "g", item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

069077 OCT 20 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)			2a DATE OF DEATH			2b HOUR		
RUSSELL ELWIN MCMILLAN			10 06 87			10:30A M		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)			7 IF UNDER 1 YEAR		
MALE	WHITE	06 29 26	61 YRS			MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH					
WV	USA		PRINCE GEORGE'S MD					
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY		
CHEVERLY	PRINCE GEORGE'S HOSPITAL CENTER		Maintenance			Gov't		
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET ADDRESS / ZIP CODE				
MD	Calvert	Huntingtown	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	3541 Patuxent Rd./20639				
14 FATHER'S NAME (FIRST MIDDLE LAST)	15 MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					
Dinks	Minnie Ada Nester		16b SOCIAL SECURITY NO					
			17 INFORMANT ADDRESS					
			GUY E. MCMILLAN (same)					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Stroke</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Diabetes</u>								<u>many yrs</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u>								<u>many yrs</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a								
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
N/A				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE				
				84 to Oct 6 19 87				
22a I certify that (I) (this hospital) attended the deceased from _____, 19 84 to Oct 6 19 87, and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.								
22b SIGNATURE <u>Dr. L. H. Louie</u>				DEGREE MD		ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 7 Oct 87
22d PHYSICIAN'S NAME (TYPE OR PRINT) SETH B. LOURIE				22e ADDRESS 7500 Hanover Pkwy, Greenbelt MD 20770				
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE		
cremation		10-10-87		Cedar Hill		Suitland PG MD		
24 FUNERAL DIRECTOR NAME				25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
Rausch FH Owings, MD 20736				OCT 19 1987		<u>Jane Davidson-Pendley</u>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use on the burial/transit permit. Then please remove the permit, page 1, and it should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, this is a self-inflicted injury, or other traumatic event, the medical examiner must be notified promptly.

BP _____

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0-68724 OCT 15 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Robert Byron McQUIN			2a DATE OF DEATH MONTH DAY YEAR October 6, 1987		2b HOUR 4:55P M			
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Jan. 24, 1887		6 AGE (IN YEARS LAST BIRTHDAY) 100		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Iowa		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD		
10 CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctor's Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cabinet Maker		12b KIND OF BUSINESS OR INDUSTRY Navy Yard		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland			13b COUNTY P.G.		13c CITY OR TOWN Hyattsville		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Byron Marcellas McQuin			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Jensen					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-05-7845-A		17 INFORMANT 4047 Twin Arch Road Betty M. Padgett (Daughter) Mt. Airy, Md.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>multiple decompensated ulcers with infection</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>days</u> <u>months</u>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>arteriosclerotic Heart disease congestive heart failure</u>								
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)				
21d INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from <u>Jan</u> 19 <u>83</u> to <u>Oct</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>Oct</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (b) (we) (did) (did not) view the body after death.								
22b SIGNATURE <u>Tung-Pi Lee</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED		
22d PHYSICIAN'S NAME (TYPE OR PRINT) Tung-Pi Lee M.D.				22e ADDRESS 7411 Riggs Rd., Hyattsville, Md. 20783				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE 10/10/87		23c NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria		23d LOCATION CITY OR TOWN COUNTY STATE Virginia		
24 FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A.				25a DATE REC'D BY REGISTRAR OCT 14 1987				
4739 Baltimore Avenue Hyattsville, Md. 20781				REGISTRAR'S SIGNATURE <u>John Swiden</u>				

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to transportation, in case of an unusual death, or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP

0-88754-001-12 34

100-44388-100

39809 OCT 27 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

30390

1. DECEASED NAME (TYPE OR PRINT) FIRST: Isabel MIDDLE: O. LAST: Miakysita			2a. DATE OF DEATH MONTH: October DAY: 19, YEAR: 1987		2b. HOUR 7:00 AM
3. SEX F	4. RACE Cau.	5. DATE OF BIRTH MONTH: 8 DAY: 8 YEAR: 29		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.	7. UNDER 1 YEAR MONTHS: DAYS: HOURS: MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Peru	7b. CITIZEN OF WHAT COUNTRY? Peru	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD	
10. CITY OR TOWN OF DEATH Hyattsville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8120 15th Avenue		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed	12b. KIND OF BUSINESS OR INDUSTRY None	
13a. STATE Maryland	13b. COUNTY P.G.	13c. CITY OR TOWN Hyattsville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 8120 - 15th Ave. 20783	
14. FATHER'S NAME FIRST: Julio MIDDLE: LAST: Miakysita		15. MOTHER'S MAIDEN NAME FIRST: Jacinta MIDDLE: LAST: Osorio			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 577-66-8330		17. INFORMANT ADDRESS: Sister - Lucila M. Portill - Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Huntington chorea</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>Mental Retardation Anemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 21</u> 19 <u>87</u> to <u>Oct 19</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>Sept 21</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Dr. Smith</i>		DEGREE		22c. DATE SIGNED 10/19/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Smith Ho, M.D.		22e. ADDRESS 7610 Carroll Ave.,			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 21, 87	23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cem.		23d. LOCATION CITY OR TOWN: Washington, D.C. COUNTY: STATE:
24. FUNERAL DIRECTOR <i>James E. B. B.</i>		DeVol Funeral Home Washington, D.C.		25a. DATE REC'D. BY REGISTRAR OCT 26 1987	
		25b. REGISTRAR'S SIGNATURE <i>James E. B. B.</i>			

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please deliver captioned papers, Pages 1 and 2 and 3, to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

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55-2-173

2000

Oct. 21, 1907. Rock Creek, Cal.

Index

[illegible]

1. DECEASED NAME (TYPE OR PRINT) ZERNIE E. MIKO			2a. DATE OF DEATH MONTH DAY YEAR 10/12/87		2b. HOUR MIN. 130 A.M.		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 10 26 15		6. AGE (IN YEARS, LAST BIRTHDAY) 71 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE MD.	
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CLINTON CONV. CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Hair Stylist	
12b. KIND OF BUSINESS OR INDUSTRY STEWARTS		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY P.G. 13c. CITY OR TOWN Upper Marlboro		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 7222 Havre Turn	
14. FATHER'S NAME FIRST MIDDLE LAST Guy — BRILL		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CORA BRILL		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216-28-9739	
17. INFORMANT ADDRESS UPPER MARLBORO MD 20772		17. INFORMANT NAME DENNIS MIKO		17. INFORMANT ADDRESS 7222 HAVRE TURN MD 20772		17. INFORMANT NAME DENNIS MIKO	

18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) ATROPHIC CARDIOVASCULAR DISEASE			
DUE TO, OR AS A CONSEQUENCE OF (c) _____			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) SEIZURE DISORDER, URINARY TRACT INFECTION			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from April 10 19 87 to Oct 12 19 87 that (we) last saw the deceased alive on Oct 1 19 87 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)			
22b. SIGNATURE FRANK A. RYAN MD.		22c. DATE SIGNED 10/12/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 9401 Indian Head Highway, Wash MD	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/14/87		23c. NAME OF CEMETERY OR CREMATORY GLEN HAVEN MEMORIAL PK		23d. LOCATION CITY OR TOWN COUNTY STATE GLEN BURNIE MARYLAND	
24. FUNERAL DIRECTOR NAME ADDRESS LEROY M & RUSSELL C WITZKE FUNERAL HOMES 1630 EDMONDSON AVE. CATONSVILLE MD 21228				25a. DATE REC'D. BY REGISTRAR 10-19-87		25b. REGISTRAR'S SIGNATURE	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLES M MILLER			2a. DATE OF DEATH MONTH DAY YEAR 10 10 87		2b. HOUR 10/10 P M
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR 12 7 11		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Southern Maryland		MD
10. CITY OR TOWN OF DEATH Southern	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Composing Analyst		12b. KIND OF BUSINESS OR INDUSTRY Wash. Post
13a. STATE Maryland	13b. COUNTY PG	13c. CITY OR TOWN Ft. Wash.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS, ZIP CODE 2600 Brinkley Rd. #T-10 20744	
14. FATHER'S NAME FIRST MIDDLE LAST Elmer Miller		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nava Ash		ADDRESS Ft. Washington, MD	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO 503-05-6986		17. INFORMANT Cynthia Degostino 2600 Brinkley Rd #T-10	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Acute Myocardial Infarction</u> (c) <u>Arteriosclerotic Heart Disease</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Chronic Obstructive Lung Disease</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (a) (this hospital) attended the deceased from <u>10/5</u> , 19 <u>87</u> , to <u>10-10</u> , 19 <u>87</u> , that (b) (we) last saw the deceased alive on <u>10-10</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death.					
22b. SIGNATURE R.H. McConaughy MD		DEGREE		22c. DATE SIGNED 10-11-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R.H. McConaughy MD		22e. ADDRESS 5618 ST. BARNABUS Rd. OXON HILL Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal	23b. DATE 10-10-87	23c. NAME OF CEMETERY OR CREMATORY Georgetown Univ Med. School	23d. LOCATION CITY OR TOWN COUNTY STATE Washington DC		
24. FUNERAL DIRECTOR NAME Robert G. Mason		ADDRESS 1641 Good Hope Rd SE.		25a. DATE REC'D BY REGISTRAR OCT 19 1987	

DHMH - 16 60M 7/B4

(VRA 15, 1/1)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked "or" item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

30 OCT 1965

OCT 19 1965

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATHFOR
1 - STATE
REGISTRAR

REG. NO.

070638 NOV-87

DECEASED NAME (TYPE OR PRINT) MARION M. MILLER			2a DATE OF DEATH MONTH DAY YEAR 10 25 87		2b HOUR 6 ^A _M
1 SEX FEMALE	4 RACE CAUCASIAN	5 DATE OF BIRTH MONTH DAY YEAR May 22, 1900		6 AGE (IN YEARS LAST BIRTHDAY) 87 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Prince George		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George MD	
10 CITY OR TOWN OF DEATH Hyattsville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Manor Nursing Home		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Typist		12b KIND OF BUSINESS OR INDUSTRY U.S.Govt.
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland 13b COUNTY P.G. 13c CITY OR TOWN Hyattsville			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST Henry V. Miller			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida K. Kerber		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO. 579-60-0075		17 INFORMANT Elizabeth Ann Ryan	
				ADDRESS Rockville, Md. 13401 Grenable Dr.	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE CORONARY THROMBOSIS					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SECONDS
DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROTIC CARDIORENAL VASCULAR DISEASE					YEARS
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 MITRAL INSUFFICIENCY; CEREBRAL ISCHEMIA					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18B PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from JANUARY 19 83 to OCTOBER 25 19 87 that (I) (we) last saw the deceased alive on OCTOBER 25 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b SIGNATURE Marta Anne Schneider MD				22c DATE SIGNED 10/25/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) MARTA ANNE SCHNEIDER MD				22e ADDRESS 5401 MACARTHUR BLVD. NW. WASH. D.C. 20016	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Oct. 28, 1987		23c NAME OF CEMETERY OR CREMATORY Glenwood Cemetery	
23d LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.					
24 FUNERAL DIRECTOR NAME John F. DeVol				25a DATE REC'D. BY REGISTRAR NOV 2 1987	
DeVol Funeral Home Washington, D.C.				25b REGISTRAR'S SIGNATURE John F. DeVol	

050730 NOV-80

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 070932 NOV -6 87
 1- STATE REGISTRAR

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR M	
WILLIAM A. MINDER				10-29-87		2.50A	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Male	Caucasian	Jan. 5, 1937		50 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland	United States			PRINCE GEORGE		MD	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (TYPE OF FACILITY AND ITS OWN STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
CHEVERLY	PRINCE GEORGES HOSPITAL CENTER		Gravedigger		Cemetery		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Maryland		Pr. Geo.		Seat Pleasant		13e. STREET ADDRESS / ZIP CODE Gregg Street 20743	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Jacob A. Minder		Mary I. Sollers					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
no		ds 578-48-2151		Frank W. Minder, Gen'l. Del. Point,		Piney Md.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>morbid obesity</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>PICKWICKIAN Syndrome</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a <u>chronic cellulitis</u>		

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18B PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>10-28</u> 19 <u>87</u> to <u>10-29</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>10-28</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) not view the body after death.							
22b. SIGNATURE <u>Sean W. Leehan MD</u>		DEGREE		22c. DATE SIGNED 10-29-87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sean W. Leehan		22e. ADDRESS 1 HOSPITAL DRIVE CHEVERLY, MD. 20785					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		Nov. 3, 87		Cedar Hill		Suitland, Prince Geo., MD	
24. FUNERAL DIRECTOR NAME <u>John J. Bell</u> ADDRESS				25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>John J. Bell</u>	
Bell Funeral Service, Prince Frederick, Md.				NOV 5 1987			

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70953 NOV-68

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 30401

1- FOR
STATE
REGISTRAR

REG. NO.

2- DECEASED NAME
(TYPE OR PRINT)

FIRST MIDDLE LAST
LETA O. MISER

2a DATE OF DEATH MONTH DAY YEAR 2b HOUR
10 29 87 6-15A.M.

3 SEX

Femlae

4 RACE

Caucasian

5. DATE OF BIRTH

MONTH DAY YEAR
06/ 01/ 21

6 AGE (IN YEARS (LAST BIRTHDAY))

66

IF UNDER 1 YEAR

IF UNDER 24 HRS

7a BIRTHPLACE

(STATE OR FOREIGN COUNTRY)

North Carolina

7b CITIZEN OF WHAT COUNTRY?

US

8 MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Prince George's

MD

10 CITY OR TOWN OF DEATH

Laurel

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Greater Laurel Beltsville Hosp. Homemaker

12a USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE)

12b KIND OF BUSINESS OR INDUSTRY

Home

13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13b STATE

Md.

13c. COUNTY

Balto.

13d. CITY OR TOWN

Balto.

13e INSIDE CITY LIMITS?

YES ☒ NO ☐

13f STREET ADDRESS / ZIP CODE

#Lot 27

7734 Washington Blvd.

14 FATHER'S NAME

FIRST

L.

MIDDLE

C.

LAST

Franklin, Sr.

15. MOTHER'S MAIDEN NAME

FIRST

Fannie

MIDDLE

21227

LAST

Shelton

16a WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)

n/a

16b SOCIAL SECURITY NO.

(IF YES, GIVE WAR OR DATES)

n/a

17 INFORMANT

ADDRESS

215-24-6105

18 CAUSE OF DEATH

(Enter only one cause per line for (a), (b), and (c))

PART 1 DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

HEPATO RENAL FAILURE.

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) ACUTE FULMINANT HEPATITIS Complicated

DUE TO, OR AS A CONSEQUENCE OF

(c) by Renal failure, coagulopathy.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

ANAEMIA, CARDIOMEGALY, ARTERIOSCLEROSIS, ARTHRITIS

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

YES ☐ NO ☐

20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER NOTIFY MEDICAL EXAMINER)

21b TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21b PART 1 OR PART 2)

21d INJURY OCCURRED

WHILE ☐ NOT WHILE ☐AT WORK ☐ AT WORK ☐

21e PLACE OF INJURY

(AT HOME STREET FACTORY OFFICE, FARM, ETC.)

21f LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a I certify that (I) (this hospital) attended the deceased from 10/12/1987 to 10/29/1987 that (I) (we) last saw the deceased alive on 10/28/1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death

22b SIGNATURE

Abdul Nayeem

DEGREE

M.D.

ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c DATE SIGNED

10/29/87

22d PHYSICIAN'S NAME (TYPE OR PRINT)

ABDUL NAYEEM M.D.

22e ADDRESS

3450-FORT MEADE ROAD, LAUREL, M.D. 20707

23a BURIAL, CREMATION, REMOVAL

(SPECIFY)

Burial

23b DATE

11/2/87

23c NAME OF CEMETERY OR CREMATORY

Meadowridge Cem.

23d LOCATION

Jessup

Howard Md.

24 FUNERAL DIRECTOR

7601 Sandy Spring Rd.

Fleck Funeral Home, Inc. Laurel, Md. 20707

25a DATE REC'D BY REGISTRAR

NOV 5 1987

25b REGISTRAR'S SIGNATURE

Lester R. Rucker

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, it must be certified to the coroner for notification of the coroner.

BP

70058 MAY 507



North Carolina
Franklin, N.C.
215-24-0105
11/2/57
7501
which

068178

OCT 9 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

30402

REG NO

1. DECEASED NAME (TYPE OR PRINT) Dorothy Frances Monticello				2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 10-6-87				2b. HOUR M M							
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10-23-18		6. AGE (IN YEARS) LAST BIRTHDAY 68 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10-6-87		7d. HOUR M M			
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Chicago, Ill.				7c. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD			
10. CITY OR TOWN OF DEATH Clinton				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Southern Maryland Hospital				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Homemaker				12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. STATE California				13b. COUNTY Sonoma				13c. CITY OR TOWN Petaluma				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
13e. STREET ADDRESS 1398 Schuman Rd. 1300 Schuman Lane				14. FATHER'S NAME FIRST MIDDLE LAST John Bushka				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jennifer							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Unk				17. INFORMANT Salvatore Monticello				ADDRESS Same as 13 A-E			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE OF DEATH Dilated cardiac rupture and myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE Augusto P. Rodriguez				TITLE (SPECIFY) Deputy				DATE SIGNED 10-6-87							
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.				ADDRESS 5009 Rayburn Ct, Temple Hills, MD											
23a. BURIAL, CREMATION, REMOVAL Burial				23b. DATE 10/09/87		23c. NAME OF CEMETERY OR CREMATORY Cyprus Hill Mem. Park				23d. LOCATION Petaluma Sonoma Calif.					
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.				25a. DATE REC'D BY REGISTRAR OCT - 8 1987				25b. REGISTRAR'S SIGNATURE Julia Davidson-Rodriguez							
26. ADDRESS 16633 Old Alexander Ferry Rd Clinton, Md 20735															

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENALTY IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 2. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL "TRANSFER PERMIT." PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

949679
BP
DHMM 117
VB 415 N6633

068170 OCT-88

Deputy Monticello

Deputy Monticello

Deputy Monticello

Deputy Monticello

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carboncopies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to burial.

DHMH 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LILA MAE MORELAND			2a. DATE OF DEATH MONTH DAY YEAR 10 25 87		2b. HOUR 3 A M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 9 01 1897		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS	IF UNDER 1 YEAR MONTH DAY HRS IF UNDER 2 HRS HRS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD	
10. CITY OR TOWN OF DEATH CLINTON MD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Anne Arundel	13c. CITY OR TOWN Lothian	
14. FATHER'S NAME FIRST MIDDLE LAST John William Crandell			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lyda Ann Dawson	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO 218366520	17. INFORMANT George A. Moreland same as #13	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Acute PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>MULTIPLE CVA</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>19 Days</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/25</u> 19 <u>87</u> to <u>10/25</u> 19 <u>87</u> that I (we) last saw the deceased alive on <u>10/25</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Michael J. Levine				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL LEVINE				22e. ADDRESS 7801 OLD BRANCH AVE CLINTON MD 20735	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/28/87		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion UMC Cem.	
23d. LOCATION (CITY OR TOWN) COUNTY STATE Lothian A. Arundel Md.		23e. DATE REC'D. BY REGISTRAR OCT 27 1987			
24. FUNERAL DIRECTOR NAME H. H. F. H.		24b. ADDRESS 12 Ridgely Ave.		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

BP

082010 OCT 28 81

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7-30404

1- FOR
STATE
REGISTRAR

REG. NO.

DECEASED NAME (LAST OR PRINT)		FIRST	MIDDLE	LAST	2a DATE OF DEATH MONTH DAY YEAR	2b HOUR
Esther		E.		Mortensen	Oct. 8, 1987	3 A M
3 SEX	4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
Female	White		May 5, 1900		87	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
Massachusetts	United States				Prince George's MD	
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Adelphi	Presidential Woods Health Care Center		Nurses Aide		Hospital	
13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET ADDRESS		
Maryland	Prince George's	Adelphi	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	1801 Metzert Road / 20783		
14 FATHER'S NAME FIRST MIDDLE LAST	15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			
Roy	Haskell		Grace Thompson			
16b SOCIAL SECURITY NO		17 INFORMANT ADDRESS				
No		10004 Connecticut Ave. Priscilla A. Jones, Kensington, MD 20895				

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Natural Causes.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		
(b) _____		
DUE TO, OR AS A CONSEQUENCE OF		
(c) _____		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CVA x2, Pneumonia, Feeding Gastrostomy.</u>			
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (1) (this hospital) attended the deceased from <u>Sept 24, 1987</u> to <u>Oct. 8, 1987</u> that (1) (we) last saw the deceased alive on <u>Sept 24, 1987</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (and) (did not) view the body after death.			
22b SIGNATURE <u>Stuart Turkewitz</u>	DEGREE <u>MD</u>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED <u>10/8/87</u>
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>Stuart Turkewitz</u>		22e ADDRESS <u>7500 Greenway Cntr. Dr. Greenbelt, Md. 20770</u>	

23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION CITY OR TOWN COUNTY STATE
Cremation	10-8-87	Metropolitan Crematory	Alexandria, Virginia
24 FUNERAL DIRECTOR NAME		25a DATE REC'D. BY REGISTRAR	25b REGISTRAR'S SIGNATURE
Richard Rapp, Inc.		OCT 09 1987	<u>John F. Rapp</u>
P. O. Box 43352, Washington, DC 20010			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Klan

Moutsos

2a DATE OF DEATH

MONTH

DAY

YEAR

7b HOUR

10 29 87

1430 PM

3 SEX

Male

4 RACE

White

5. DATE OF BIRTH

MONTH

DAY

YEAR

4 2 24

6 AGE (IN YEARS LAST BIRTHDAY)

63

YRS.

IF UNDER 1 YEAR

MONTH

DAY

HOUR

MIN.

7a BIRTHPLACE

(STATE OR FOREIGN COUNTRY)

Albania

7b CITIZEN OF WHAT COUNTRY?

USA

8 MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Prince Georges

MD

10 CITY OR TOWN OF DEATH

Hyattsville

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

(IF NOT IN HEALTH FACILITY, GIVE STREET ADDRESS)
6016 40th. Avenue

12a USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret. Waiter

12b KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

Maryland

13b COUNTY

Pr. Georges

13c CITY OR TOWN

Hyattsville

13d INSIDE CITY LIMITS?

YES ☒ NO ☐

12c STREET ADDRESS / ZIP CODE

6016 40th. Avenue

20782

14 FATHER'S NAME

Chris

MIDDLE

Moutsos

15 MOTHER'S MAIDEN NAME

Alexandra

MIDDLE

Eleades

16a WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO, OR UNKNOWN)
N/A(IF YES, GIVE WAR OR DATES)
N/A

16b SOCIAL SECURITY NO.

196-30-6436

17 INFORMANT

ADDRESS

Koula Moutsos-wife-(same as 13c)

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART 1 DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Cardiac Arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

(b) Inoperable Co. Pancreas

DUE TO, OR AS A CONSEQUENCE OF

(c) Hypertensive Cardio Vascular Disease

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

20

2/7/87

8 mos

5 yrs Plus

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Atherosclerosis, Bilectical Carotid Surgery

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY

YES ☐ NO ☒

20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c HOW INJURY OCCURRED

(ENTER NATURE OF INJURY (SYSTEM OR PART) OR PART 2)

21d INJURY OCCURRED

21e PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f LOCATION

STREET

(CITY OR TOWN)

COUNTY

STATE

22a I certify that (1) [this hospital] attended the deceased from June 19 82 to October 29 19 87 that I have last saw the deceased alive on Oct 23 19 87, and that in my [my] opinion death occurred on the date and hour and from the causes stated above. (If I [we] [did] not view the body after death)

22b SIGNATURE

DEGREE

ATTENDING
PHYSICIAN ☒MEDICAL
DIRECTOR ☐STAFF
PHYSICIAN ☐

22c DATE SIGNED

29 OCT 87

22d PHYSICIAN'S NAME (TYPE OR PRINT)

Gordon W. Kelley

22e ADDRESS

6124-41st Ave, Hyattsville, Md 20782

23a BURIAL, CREMATION, REMOVAL

(SPECIFY)

Burial

23b DATE

Nov. 2, 1987

23c NAME OF CEMETERY OR CREMATORY

Gate of Heaven

23d LOCATION

Silver Spring Montgomery Md.

24 FUNERAL DIRECTOR

Hines/Rinaldi Funeral Home 11800 N.H. Ave./
Silver Spring, Md.

25a DATE REC'D BY REGISTRAR

NOV 3 1987

25b REGISTRAR'S SIGNATURE

Julia Davidson-Randall

070718 101-407



NOV 3 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 DECEASED NAME (TYPE OR PRINT) PHYLLIS Elizabeth MOYLAN			2a DATE OF DEATH MONTH DAY YEAR 10 12 87			2b HOUR 11 15AM			
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR 09 12 07		6 AGE (IN YEARS LAST BIRTHDAY) 80 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN 0 0 0 0	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.			
10 CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S HOSPITAL CENTER				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager		12b KIND OF BUSINESS OR INDUSTRY Food Services	
13a STATE Maryland		13b COUNTY P.G.		13c CITY OR TOWN Bladensburg		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 5999 Emerson Street 20710	
14 FATHER'S NAME FIRST MIDDLE LAST Thomas Rice				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Phoebe Ann Doores				16 ADDRESS 5218 57th Avenue Riverdale, Md. 20737	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 579-32-9985-A		17 INFORMANT (Daughter) Jane T. Ingwersen				17b ADDRESS Riverdale, Md. 20737	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (c) Renal failure								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 10/12/87 to 10/12/87 that (I) (we) last saw the deceased alive on 10/12/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
22b SIGNATURE [Signature]						DEGREE MD		22c DATE SIGNED 10-13-87	
22d PHYSICIAN'S NAME S. KUNSA						22e ADDRESS PGU HOSPITAL 20785			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 10/15/87		23c NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Brentwood, P.G. Maryland		
24a NAME OF FUNERAL HOME Francis Gasch's Sons Funeral Home, P.A.						24b ADDRESS 4739 Baltimore Avenue Hyattsville, Md. 20781			
25a DATE OF DEATH BY REGISTRATION OCT 19 1987						25b REGISTRAR'S SIGNATURE [Signature]			

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH 16 60M 7/84
(VRS 1, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR STATE REGISTRAR		2a DECEASED NAME AKA FIRST FRANCIS MIDDLE H. LAST MULCAHY REV. TURIBIUS GABRIEL MULCAHY, S.T.		2b DATE OF DEATH MONTH DAY YEAR OCTOBER 1, 1987		2c HOUR 8:30 M	
3 SEX MALE		4 RACE CAUCASIAN		5 DATE OF BIRTH MONTH DAY YEAR JANUARY 11, 1896		6 AGE (IN YEARS LAST BIRTHDAY) 91 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD	
10 CITY OR TOWN OF DEATH HYATTSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL MANOR		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PRIEST		12b KIND OF BUSINESS OR INDUSTRY RELIGIOUS	
13a STATE MARYLAND		13b COUNTY MONTGOMERY		13c CITY OR TOWN SILVER SPRING		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST TIMOTHY HALPIN MULCAHY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY FRANCES MULLANEY		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II	
17 INFORMANT SUPERIOR		ADDRESS 9001 NEW HAMPSHIRE REV. LEON BUGGY, S.T. SILVER SPRING, MD. 20903					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancer Respiratory Tract</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic Lung Failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <i>4 years</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a <i>none</i>							
19a DATE OF OPERATION <i>none</i>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) lost saw the deceased alive on 8/14 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <i>Daniel J. Boyle</i>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10/2/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) DANIEL J. BOYLE, M.D.		22e ADDRESS 10313 GEORGIA AVENUE SILVER SPRING, MD.					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE OCT. 7, 1987		23c NAME OF CEMETERY OR CREMATORY HOLY TRINITY CEMETERY		23d LOCATION CITY OR TOWN COUNTY STATE FT. MITCHELL RUSSELL ALABAMA	
24 FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD. W. SILVER SPRING, MD. 20901				25a DATE REC'D. BY REGISTRAR OCT 07 1987			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO 39408

1- STATE REGISTRAR		DECEASED NAME THELMA VERNELL MULLIS		2a. DATE KNOWN OF DEATH 10 9 1987		2b. HOUR 12:25 PM	
3 SEX Female	4 RACE White	5 DATE OF BIRTH Oct. 13, 1960	6 AGE (IN YEARS) 26 YRS	7a BIRTHPLACE North Carolina	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED NEVER MARRIED WIDOWED DIVORCED	9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD
10 CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Prince George's General Hospital		12a USUAL OCCUPATION Binder		12b KIND OF BUSINESS Reproduction Consultants, Inc.	
13a STATE Maryland		13b COUNTY Anne Arundel		13c CITY OR TOWN Lothian		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME John Henry Mullis		15 MOTHER'S MAIDEN NAME Thelma Vernice Mullis		16a WAS DECEASED EVER IN U.S. ARMED FORCES? No		17 INFORMANT Thelma Vernice Mullis-Park, Box 10, Lothian Md. 21071	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Gunshot wound of head (unspecified weapon)
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	70 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b TIME OF INJURY 8:20 P.M. 10-3- 19 87	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Subject shot.
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street	21f LOCATION 7300 blk. Landover Rd. Prince George's, MD

22a I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐.

ACTUAL SIGNATURE Mario F. Golle, Jr. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 10-10-87

EXAMINER'S NAME (TYPE OR PRINT) Mario F. Golle, Jr., M.D. ADDRESS 111 Penn St., Balto., MD 21201

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 10/15/87	23c NAME OF CEMETERY OR CREMATORY LAEAYETTE MEMORIAL PARK	23d LOCATION (CITY OR TOWN) Fayetteville, N.C.
24 FUNERAL DIRECTOR Richard A. Coleman Funeral Home		25a DATE REC'D BY REGISTRAR OCT 19 1987	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that each certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the law, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

Item 23c, Film 0633 11-1-87 dw

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Beulah L Munford			2a. DATE OF DEATH MONTH DAY YEAR October 18, 1987		2b. HOUR MIN 5:55 P
3 SEX Female	4 RACE Black	5. DATE OF BIRTH MONTH DAY YEAR June 5 1908		6 AGE (IN YEARS LAST BIRTHDAY) YEARS MONTHS DAYS 79	IF UNDER 1 YEAR IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George MD	
10 CITY OR TOWN OF DEATH Clinton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital Ctr.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic	12b KIND OF BUSINESS OR INDUSTRY Home	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland		13b COUNTY Pr Geo	13c CITY OR TOWN Suitland	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 3417 Keir Drive 20746
14 FATHER'S NAME FIRST MIDDLE LAST Wash Langford		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Zula Polk			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NAME OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No	16b SOCIAL SECURITY NO. 412 24 6933	17 INFORMANT ADDRESS Fred Munford Jr Same as #13			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Sepsis DUE TO, OR AS A CONSEQUENCE OF (b) Dissecting Aneurysm Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. UTI - Renal failure - Dialysis - ASH - Scleroderma					
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 9/17 , 19 87 , to 10/18 , 19 87 , that (I) (we) last saw the deceased alive on 10/17 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Robert E Wilhelm		DEGREE MD		22c DATE SIGNED 10/18/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Robert E Wilhelm		22e ADDRESS 4235 26 Ave NW 20746			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 22 Oct 1987	23c NAME OF CEMETERY OR CREMATORY GOLDEN HILL Cemetery	23d LOCATION CITY OR TOWN COUNTY STATE Clarksville Tenn		
24 FUNERAL DIRECTOR NAME Robert E Wilhelm		ADDRESS Suitland Maryland		25a DATE REC'D BY REGISTRAR OCT 23 1987	25b REGISTRAR'S SIGNATURE John W. ...

06988 OCT 22 67

October 19, 1967

MEMPHIS

Program

Branch

Hydros Service

Southwestern Maryland Hospital Unit

Clinton

October 19, 1967

OCT 23 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 showing any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH 16 60M 7/84
(VRA 15, 4)

068704

OCT 15
FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BAXTER HALL MURPHREE			2a DATE OF DEATH MONTH DAY YEAR OCTOBER 11, 1987		2b HOUR 8:55A M
3 SEX MALE	4 RACE CAUCASIAN	5 DATE OF BIRTH MONTH DAY YEAR FEBRUARY 18, 1923		6 AGE (IN YEARS LAST BIRTHDAY) 64 YRS	7 UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MISSISSIPPI	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.	
10 CITY OR TOWN OF DEATH TAKOMA PARK	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7228 MINTER PLACE		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BROKERAGE MANAGER		12b KIND OF BUSINESS OR INDUSTRY PRUDENTIAL INS.
13a STATE MARYLAND		13b COUNTY PR GEORGES	13c CITY OR TOWN TAKOMA PARK	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST BAXTER C. MURPHREE		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELEANOR WHITE		13e STREET ADDRESS / ZIP CODE 7228 MINTER PLACE 20912	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 1950-1953		17 INFORMANT ADDRESS DOROTHY W. MURPHREE/WIFE/SAME AS 13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic Renal Cancer</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE	
22 I certify that (I) (this hospital) attended the deceased from <u>July 19 87</u> to <u>October 19 87</u> that (I) (we) last saw the deceased alive on <u>Oct 19 87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (and) (and) not within the body after death.					
22a SIGNATURE <u>[Signature]</u>		DEGREE		22c DATE SIGNED 10-12-87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) DR FRED SMITH		22e ADDRESS 5401 WESTERN AVENUE WASHINGTON D.C.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE OCT15, 1987	23c NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		23d LOCATION CITY OR TOWN COUNTY STATE ROCKVILLE MONTGOMERY MARYLAND
24 FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901			25a DATE REC'D. BY REGISTRAR OCT 14 1987		

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TIME: 10:00

LOCATION: 101103

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DATE: 10-1-80

TIME: 10:00

LOCATION: 101103

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(CA: 101103) UNCLASSIFIED

DATE: 10-1-80

TIME: 10:00



UNCLASSIFIED

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DATE: 10-1-80

TIME: 10:00

LOCATION: 101103

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

3 0 4 1 2

1. DECEASED NAME (TYPE OR PRINT) ROBERT J. Nagle			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH 10 DAY 10 YEAR 1987			2b. HOUR M
3. SEX Male	4. RACE Cauc.	5. DATE OF BIRTH MONTH Oct. DAY 24 YEAR 1964	6. AGE (IN YEARS) YEARS 22	IF UNDER 1 YR. MONTHS DAYS 	IF UNDER 24 HRS. HOURS MIN 	2c. DATE PRONOUNCED DEAD MONTH 10 DAY 10 YEAR 1987
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD
10. CITY OR TOWN OF DEATH Bowie		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) N/B Rt. 301 no. of Rt. 197		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY Drywall Co.
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						
13a. STATE Maryland	13b. COUNTY Prince Geo.	13c. CITY OR TOWN Bowie	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET ADDRESS 12701 Kernwood Lane/20715		
14. FATHER'S NAME FIRST Bernard MIDDLE T. LAST Nagle			15. MOTHER'S MAIDEN NAME FIRST Joyce MIDDLE E. LAST Dove			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-88-6523		17. INFORMANT ADDRESS Joyce E. Nagle, Same as # 13.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Multiple injuries**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

(b) _____
DUE TO, OR AS A CONSEQUENCE OF

(c) _____

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR 10:45 MONTH 10 DAY 10 YEAR 1987	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Operator of motorcycle/tractor trailer collision.	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.) road	21f. LOCATION STREET N/B Rt. 301 No. of Rt. 197, Prince George's, CITY OR TOWN Prince George's, COUNTY MD	
22a. I certify that I took charge of the remains described above, held on death resulted from <input type="checkbox"/> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE Mario F. Golle, Jr.		TITLE (SPECIFY) Assistant MEDICAL EXAMINER		DATE SIGNED 10-11-87
EXAMINER'S NAME (TYPE OR PRINT) Mario F. Golle, Jr., M.D. ADDRESS 111 Penn St., Balto., MD 21201				

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE Oct. 16, 1987	23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory	23d. LOCATION CITY OR TOWN Alexandria, Fairfax, Virginia COUNTY STATE
24. FUNERAL DIRECTOR NAME Beall Funeral Home ADDRESS 16000 Annapolis Rd Bowie, Maryland		25a. DATE REC'D BY REGISTRAR OCT 16 1987 25b. REGISTRAR'S SIGNATURE Julia S. [Signature]	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH PAGES 1, 2, AND 3. RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGE 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

30413
REG NO

1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a DATE KNOWN OF DEATH ESTI MATED		MONTH		DAY		YEAR		1b HOUR					
Deidre		C.		Nealon				10/ 2/ 19 87								M					
2 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS) (LAST BIRTHDAY)		IF UNDER 1 YR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		1d HOUR	
Female		White		July 30, 1960		27 YRS.						10/ 2/ 19 87								6:35 P M	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH													
New Jersey		United States						Prince George's County, MD													
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY															
Bowie		4161 New Haven Dr.		Adjuster		Insurance															
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS													
Virginia		Fairfax		Fairfax				8925 Colesbury Place / 22031													
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST																			
John J. Nealon		Iris M. Radermacher																			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)		17 INFORMANT ADDRESS																	
No		153-58-7894		John G. Nealon, Same as 13																	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Cardiac Arrhythmia		DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last				DUE TO, OR AS A CONSEQUENCE OF																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																	
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE																	
22a I certify that I took charge of the remains described above, held an		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from		Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED																	
Charles P. Kokes, M.D.		Assistant		10/3/87																	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS																			
Charles P. Kokes, M.D.		111 Penn St., Balto., Md. 21201																			
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE															
Cremation		10-7-87		Metropolitan Crematory		Alexandria, Virginia															
24 FUNERAL DIRECTOR NAME		25a DATE REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE																	
Richard Rapp Inc.		OCT 8 1987		Julia Davidson-Rudolph																	
P. O. Box 43352, Washington, DC 20010																					

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07 84
25M

DHMH - 17
(VR A15 ME (5))

100-720 815880

RECEIVED OCT 10 1962

100-720 815880

100-720 815880



100-720 815880

069845 OCT 27 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, page 1 and 2 which be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

FOR
STATE
REGISTRAR
 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CAMILLA Hicks NEGUS			7a. DATE OF DEATH MONTH DAY YEAR 10-17-87		2b. HOUR 3:15 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR December 18, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 76	IF UNDER 1 YEAR MONTHS YEARS MONTHS YEARS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD	
10. CITY OR TOWN OF DEATH Riverdale	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4410 Tuckerman Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse	12b. KIND OF BUSINESS OR INDUSTRY Doctor's Hosp.	
13a. STATE Maryland		13b. COUNTY P.G.	13c. CITY OR TOWN University Park	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET ADDRESS / ZIP CODE 4410 Tuckerman Street 20782
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Hicks		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie L. Boyer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO 577-16-7598		17. INFORMANT Christine T. Plant (Daughter) University Park Md. 20782	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Adenocarcinoma of PANCREAS DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTER-VAL BETWEEN DEATH AND REPORT 6 mos
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 2 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 2/87 19 to 10/17/87 19 that if (last) saw the deceased alive on 10/15/87 19 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (If (saw) did not, view the body after death)					
22b. SIGNATURE Henry C. Soruggs MD		DEGREE		22c. DATE SIGNED 10/17/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HENRY C. SORUGGS MD		22e. ADDRESS 5415 Cedar Lane Bethesda Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/19/87	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland
24. FUNERAL DIRECTOR NAME Francis Gasch's Sons Funeral Home, P.A.			25a. DATE REC'D BY REGISTRAR 10/20/87		
4739 Baltimore Avenue Hyattsville, Md. 20781			25b. REGISTRAR'S SIGNATURE		

BP _____

06242 101211

1. The first part of the report is a general description of the project. It includes the title, the objectives, the scope, and the organization of the project. The title is "The Effect of Temperature on the Rate of Reaction of Hydrogen Peroxide with Potassium Iodate". The objectives are to determine the effect of temperature on the rate of reaction and to determine the activation energy of the reaction. The scope is limited to the reaction of hydrogen peroxide with potassium iodate in acidic solution. The organization of the project is as follows: a general description of the project, a description of the experimental procedure, a description of the results, and a conclusion.

2. The second part of the report is a description of the experimental procedure. It includes the materials, the apparatus, and the procedure. The materials are hydrogen peroxide, potassium iodate, and sulfuric acid. The apparatus is a 250 ml Erlenmeyer flask, a 10 ml graduated cylinder, and a thermometer. The procedure is as follows: a solution of potassium iodate is prepared in a 250 ml Erlenmeyer flask. A solution of hydrogen peroxide is prepared in a 10 ml graduated cylinder. The two solutions are mixed in the Erlenmeyer flask. The temperature of the mixture is measured. The time taken for the reaction to complete is measured. The rate of reaction is determined from the time taken for the reaction to complete.

3. The third part of the report is a description of the results. It includes the data, the graphs, and the conclusions. The data is as follows:

Temperature (°C)	Time taken for reaction to complete (s)
10	120
20	60
30	30
40	15
50	8

The graphs are as follows:

Graph 1: A plot of the natural logarithm of the time taken for the reaction to complete versus the reciprocal of the absolute temperature. The data points are as follows:

1/T (K ⁻¹)	ln t (s)
0.00303	4.79
0.00312	4.39
0.00321	3.99
0.00330	3.59
0.00339	3.19

Graph 2: A plot of the rate of reaction versus temperature. The data points are as follows:

Temperature (°C)	Rate of reaction (1/t)
10	0.0083
20	0.0167
30	0.0333
40	0.0667
50	0.125

The conclusions are as follows: The rate of reaction increases with temperature. The activation energy of the reaction is 50 kJ/mol.

67. FOR
STATE
REGISTRAR


STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (PRINT OR PRINT)		2a DATE OF DEATH MONTH DAY YEAR		2b HOUR	
Donald		Ralph		Neilan	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR	
Male		Caucasian		Oct. 18, 1923	
6a BIRTHPLACE (COUNTRY)		6b CITIZEN OF WHAT COUNTRY?		6c AGE (IN YEARS LAST BIRTHDAY) YRS	
Kansas		U.S.A.		63	
7a BIRTHPLACE (COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Clinton		U.S.A.		9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Clinton		Southern Maryland Hosp. Center		systems tech.	
12b KIND OF BUSINESS OR INDUSTRY		13a INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13b STREET ADDRESS / ZIP CODE	
telephone				9101 Spring Acres Road 20735	
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	
Ralph E. Neilan		Anna J. Block		Yes WW II	
16b SOCIAL SECURITY NO		17 INFORMANT		18 ADDRESS	
578-20-5371		Pauline T. Neilan		Same as # 13 a-e.	

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic lung cancer</u>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: g

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
			YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NURSE OR MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> ON DUTY <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT ON DUTY <input type="checkbox"/>	21e PLACE OF INJURY 1. AT HOME 2. STREET 3. FACTORY 4. OFFICE 5. FARM ETC.	21f LOCATION CITY/TOWN COUNTY STATE		
22a I certify that (1) this hospital attended the deceased from <u>Oct 7</u> 19 <u>86</u> to <u>Oct 1</u> 19 <u>87</u> that (we) last saw the deceased alive <u>Oct 1</u> 19 <u>87</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above.				
22b SIGNATURE 	DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED <u>10/2/87</u>
22d PHYSICIAN'S NAME (LAST, FIRST, MIDDLE) <u>DR. WAIDAK</u>	22e ADDRESS <u>Clinton Md</u>			

23a BURIAL, CREMATION, REMOVAL (P.E.#)		23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION CITY OR TOWN	COUNTY	STATE
Burial		10/05/87	Maryland Veterans Cemetery	Cheltenham	P.G.	Maryland
74 FUNERAL DIRECTOR Lee Funeral Home, Inc.				25a DATE REC'D. BY REGISTRAR		
3 Old Alexander Ferry Rd Clinton Md 20735				25b REGISTRAR'S SIGNATURE		
				OCT - 8 1987 Julia Dodson-Randall		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16 60M 784
(VRA 15, 4) 60

6633 Old Alexander Ferry Rd Clinton Md 20735

25a. DATE REC'D BY REGISTRAR **OCT 8 1987** 25b. REGISTRAR'S SIGNATURE *Julia Davidson-Randall*



UNKNOWN #87-99

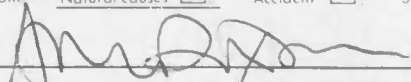
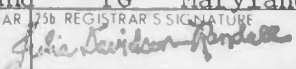
STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

30410

REG NO

FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) JAMES A. NEWBY			2a DATE KNOWN OF DEATH X MONTH DAY YEAR 9 28 19 87			2b HOUR M 10:05 AM		
3 SEX Male	4 RACE Black	5 DATE OF BIRTH MONTH DAY YEAR 08 10 1952	6 AGE (IN YEARS) (LAST BIRTHDAY) 35 YRS	IF UNDER 1 YR MONTHS DAYS HOURS MIN	IF UNDER 24 HRS	2c DATE PRONOUNCED DEAD MONTH DAY YEAR 9 28 19 87	2d HOUR M 10:05 AM	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD		
10 CITY OR TOWN OF DEATH Clinton		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital				12a USUAL OCCUPATION (TYPE OF WORK) (FOR MOST OF WORKING LIFE) Unemployed		12b KIND OF BUSINESS OR INDUSTRY None
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a STATE Maryland	13b COUNTY PG	13c CITY OR TOWN Forestville	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS 1911 Tanow Place. 20747				
14 FATHER'S NAME FIRST MIDDLE LAST Frank L. Newby			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bernice Wright					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes 1965 - 1968		16b SOCIAL SECURITY NO 578-70-1884		17 INFORMANT ADDRESS Frank L. Newby 1911 Tanow Place				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under lying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b) Cirrhosis of the liver								
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?					20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE 		TITLE (SPECIFY) M.D. Deputy Chief			MEDICAL EXAMINER		DATE SIGNED 9-29-87	
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.		ADDRESS 111 Penn St., Balto., MD 21201						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10-07-87	23c NAME OF CEMETERY OR CREMATORY Lincoln Mem. Cemetery			23d LOCATION (CITY OR TOWN) COUNTY STATE Suitland PG Maryland		
24 FUNERAL DIRECTOR NAME ADDRESS Robert G. Mason 1661 Good Hope Road, S.E.			25a DATE REC'D. BY REGISTRAR OCT 19 1987			25b REGISTRAR'S SIGNATURE 		

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

07/84
25MBP
DHMH - 17
(VR A15 ME (15))

000114 OCT 1961

3511 NOTION 8302

000114 OCT 1961

070173 OCT 29 1987

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Exodus Newman		2a. DATE OF DEATH MONTH DAY YEAR 10-23-87		2b. HOUR 1:07 AM	
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 8 24 13		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County	
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Md. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE Pa.		13b. COUNTY Phila.		13c. CITY OR TOWN Phila.	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Newman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Weatherly		16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Pa.	
17. INFORMANT ADDRESS Md.		18. SOCIAL SECURITY NO. 247-20-3885		19. STREET ADDRESS / ZIP CODE 3112 W. Gordon Street 19132	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Bile Ducts with DUE TO, OR AS A CONSEQUENCE OF Metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Hepatic Failure; H C V D;					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Oct. 8th, 1987 to Oct. 23rd, 1987 , that (I) (we) last saw the deceased alive on Oct. 22nd, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Victor S. Chupkovich		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Oct. 23rd/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Victor S. Chupkovich, M.D.		22e. ADDRESS 9131 Piscataway Rd., Clinton, Md. 20735			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/27/1987		23c. NAME OF CEMETERY OR CREMATORY Chelton Hills Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Philadelphia, Phila. Pa.		23e. DATE REC'D. BY REGISTRAR OCT 28 1987		23f. REGISTRAR'S SIGNATURE Wendell M. Baker	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP

070173 OCT 28 87

NO-32-44-1077

NO-32-44-1077

Sub 3

Prince George's County

Charles County, Maryland

Charles County, Maryland

Charles County, Maryland

Charles County, Maryland

Charles County, Maryland

Charles County, Maryland

Charles County, Maryland

Charles County, Maryland

Charles County, Maryland

Charles County, Maryland

Charles County, Maryland

Charles County, Maryland

Charles County, Maryland

Charles County, Maryland

Charles County, Maryland

Charles County, Maryland

068642 OCT 15 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

30418

REG NO

1 DECEASED NAME FIRST MIDDLE LAST Kevin Sylvester Newman			2a DATE KNOWN OF DEATH MONTH DAY YEAR 10/11/87		2b HOUR M P 10:44
3 SEX MALE	4 RACE BLACK	5 DATE OF BIRTH MONTH DAY YEAR 6 12 64	6 AGE IN YEARS (LAST BIRTHDAY) 23 YRS	7a BIRTHPLACE STATE OR MARYLAND	7b CITIZEN OF WHAT COUNTRY? US
7c DATE PRONOUNCED DEAD MONTH DAY YEAR 10/ 11/ 87		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD	
10 CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hospital		12a USUAL OCCUPATION (TYPE OF WORK) DISABLED	
12b KIND OF BUSINESS OR INDUSTRY		13a INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13b STREET ADDRESS 6427 AUTUMN GOLD 21045	
14 FATHER'S NAME FIRST MIDDLE LAST ROBERT S. NEWMAN		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FANNIE SANDERS			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS CHART	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple Injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10:25 PM 10/11/87		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) driver in auto/auto collision	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY FARM, ETC.) roadway		21f LOCATION STREET CITY OR TOWN COUNTY STATE Balto.-Wash. Pkwy. Landover, Pr. Geo., Md.	
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE 		TITLE (SPECIFY) Deputy Chief		DATE SIGNED 10/12/87	
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.		ADDRESS 111 Penn St., Balto., Md. 21201			
23a BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) ENTOMBMENT		23b DATE 10-17-87		23c NAME OF CEMETERY OR CREMATORY MARYLAND NAT. MEM. LAUREL MARYLAND	
24 FUNERAL DIRECTOR NAME E.L. PHILLIPS		ADDRESS 1721 N. MONROE ST.		25a DATE REC'D BY REGISTRAR OCT 14 1987	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07 84
25M

BP

DHMH 17
(VR A15 ME (5))

080013 OCT 12 83

30% COTTON L1368

WIKI BOND



OCT 14 1983

070839 NOV-587

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		2a DATE OF DEATH				2b HOUR			
3- ASSESSED NAME (PRINT)		7a DATE OF DEATH MONTH DAY YEAR				8 HOUR MIN			
FIRST MARGARET E. NEWMAN		10-21-87				3.45P			
4- SEX		4 RACE		5 DATE OF BIRTH		6 AGE		7 UNDER 1 YEAR	
Female		White		April 14, 1912		75 YRS			
7a BIRTHPLACE (COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Washington D.C.		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		PRINCE GEORGES MD			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a USUAL OCCUPATION		12b KIND OF BUSINESS OR INDUSTRY			
CHEVERLY		GLADYS SPELLMAN NURSING CENTER		Housewife		Own Home			
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS / ZIP CODE	
Maryland		P.G.		Landover		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6515 Perry Court 20784	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES?		16b SOCIAL SECURITY NO		17 INFORMANT	
Robert		Sanford		Margaret		Kernan		21 Beyda Court	
16a YES NO OR UNKNOWN?		16b YES (GIVE WAR OR DATES)		16b NO		16b NO		16b NO	
No		577-26-7214		Joan M. Newman (Daughter)		Baltimore, Md.			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)									
PART 1 DEATH WAS CAUSED BY									
IMMEDIATE CAUSE (a) <u>Urosepsis</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									
(b) <u>Recurring urinary tract infection</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>Dehydration</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<u>Catastrophic Hypokalemia</u>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY		21c HOW INJURY OCCURRED		(ENTER NATURE OF INJURY IN ITEM 21c OR PART 2)			
		HOUR A.M. MONTH DAY YEAR							
		P.M. 19							
21d INJURY OCCURRED		21e PLACE OF INJURY		21f LOCATION					
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		(AT HOME STREET FACTORY OFFICE FARM ETC.)		STREET CITY COUNTY STATE					
22a I certify that (this hospital) attended the deceased from <u>1-13-86</u> to <u>PRESENT 10/21/87</u> that (I/we) last saw the deceased alive on <u>10-21-87</u> and that in (my/our) opinion death occurred on the date and hour and from the causes stated above (I/we) (did/did not) view the body after death.									
22b SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED			
<u>Dr. Wallen</u>						<u>10/21/87</u>			
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS							
Dr. Wallen		Prince George's General Hospital, Cheverly, Md.							
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION			
Burial		10/26/87		Mt. Olivet Cemetery		Washington, D.C.			
24a NAME OF DIRECTOR		24b ADDRESS		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Francis Gasch's Sons Funeral Home, P.A.		4739 Baltimore Avenue Hyattsville, Md. 20781		NOV 04 1987		<u>Julia Davidson-Randall</u>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, page 2 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use on the burial permit forms. Then please remove carbon pages. Pages 1 and 2 should be filed without delay with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked to item 22 above only injury, or other traumatic event, the medical examiner must be notified.

100-100-100-100

100-100-100-100



**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG NO

1- STATE REGISTRAR

069438 OCT 23 1987

2a CEASED NAME (RE OR PRINT)		FIRST NAME		LAST NAME		2b DATE KNOWN OF DEATH		ESTIMATED MONTH		DAY		YEAR		7d HOUR	
		RALF		HENRIK		10-16-87		10		16		87		2:19P	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE	IF UNDER 1 YR	IF UNDER 24 HRS	7c DATE PRONOUNCED DEAD									
Male	White	Apr. 7, 1963	24 YRS			10-17-87									
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH									
New York		U.S.A.				Prince George's County									
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY									
		5500 blk. of Glen Avenue		Management		Marketing									
13a USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b STATE		13c COUNTY		13d CITY OR TOWN		13e INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13f STREET ADDRESS		13g CITY		13h STATE	
New Jersey		Camden		Cherry Hill		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1115 Yardley Rd.		08034		N.J.			
14a FATHER'S NAME (FIRST MIDDLE LAST)		14b MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)		15 ADDRESS											
Leif Henrik Nordberg		Eva Schulce		Cherry Hill, N.J.											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT											
No		058-40-9474		Leif H. Nordberg, 1115 Yardley Rd.											

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY			
IMMEDIATE CAUSE (a) <u>Blunt force injuries to head</u>			
DUE TO, OR AS A CONSEQUENCE OF			
(b) _____			
DUE TO, OR AS A CONSEQUENCE OF			
(c) _____			

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 10-87 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
				subject found beaten	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f LOCATION (CITY OR TOWN, COUNTY, STATE)	
		edge of a swamp		5500 blk. Glen Avenue Prince George's Co., Md.	

22a I certify that I took charge of the remains described above, held on death resulted from		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion	
Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Margie A. Korell</u>		TITLE (SPECIFY) Assistant M.D. MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.		ADDRESS 111 Penn Street	
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE	
Burial		Oct. 31, 1987	
23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (CITY OR TOWN, COUNTY, STATE)	
Clover Hill		N. Alfred, York, Maine	

ROBERT C. ALTENBURG FUNERAL HOME, INC.		25a DATE REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
6009 Harford Rd., Baltimore, Md. 21214		OCT 22 1987			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE USED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

100438 011381

20% COTTON FIBER

WATSON



070062 OCT 29 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LIZZIE M NORWOOD			2a DATE OF DEATH MONTH DAY YEAR 10/24/87		2b HOUR 4:38 PM
3 SEX F	4 RACE B	5 DATE OF BIRTH MONTH DAY YEAR SEPT 09 1909		6 AGE (IN YEARS LAST BIRTHDAY) 78	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD	
10 CITY OR TOWN OF DEATH CLINTON MD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DOMESTIC	12b KIND OF BUSINESS OR INDUSTRY PVT	
13a STATE MD		13b COUNTY PG	13c CITY OR TOWN COLLEGE PARK	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST JOHN NEAL		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MELISSA COVINGTON		13e STREET ADDRESS / ZIP CODE 6200 WESTCHESTER PK. DR. #918 20740	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. unk		17 INFORMANT ADDRESS ADA JEAN HOLMES-DAU SAME AS ABOVE	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular accident DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Recurrent, Septicemia DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Organic Brain Syndrome					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART II)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE [Signature]		DEGREE MD		22c DATE SIGNED 10/25/87	
23a PHYSICIAN NAME (TYPE OR PRINT) Glen R. Toulson		22e ADDRESS 9450 Penn. Ave. #18 Upper		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE 29 OCT 1987	23c NAME OF CEMETERY OR CREMATORY LINCOLN MEMORIAL		23d LOCATION CITY OR TOWN COUNTY STATE SUITLAND MD 20785
24 FUNERAL DIRECTOR NAME Alfred S. Pope		ADDRESS 2617 PA. AVE., S.E.		25a DATE REC'D. BY REGISTRAR OCT 28 1987	
				25b REGISTRAR'S SIGNATURE Julia Davidson-Randall	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

050005 01 50 14

070486 NOV-28

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE A. LAST O'BRIEN			2a. DATE OF DEATH MONTH 10 DAY 24 YEAR 87		2b. HOUR 1:26PM M				
3 SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR DEC. 29, 1902		6 AGE (IN YEARS LAST BIRTHDAY) 84 YRS IF UNDER 1 YEAR: MONTHS DATE HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) CANADA		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD			
10 CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGES HOSPITAL CENTER (DOA)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NURSE		12b KIND OF BUSINESS OR INDUSTRY HOSPITAL		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a STATE Md.		13b COUNTY P.G.C.		13c CITY OR TOWN HYATTSVILLE		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE CARROLL MANOR NURSING HOME 20782	
14 FATHER'S NAME FIRST FENTON MIDDLE LAST McCORMICK				15. MOTHER'S MAIDEN NAME FIRST MARY MIDDLE LAST McLAUGHLIN					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----- 372-38-9874		17 INFORMANT ADDRESS 1390 KERSEY LA. ROCKVILLE, Md. 20854					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY									
IMMEDIATE CAUSE (a) <u>Myocardial Infarction.</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>Coronary Artery Disease</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<u>Organic Brain Syndrome</u>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (u) (this hospital) attended the deceased from <u>1985</u> 19 <u>87</u> to <u>Oct 25</u> 19 <u>87</u> that (we) last saw the deceased alive on <u>Oct 25</u> 19 <u>87</u> and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) did (did not) view the body after death.									
22b SIGNATURE <u>Stuart Turkewitz</u>				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10/20/87			
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>Stuart Turkewitz</u>				22e ADDRESS <u>2500 Greenway Cat. Dr. Greenbelt, Md. 20770.</u>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b DATE 10-26-1987		23c NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY		23d LOCATION CITY OR TOWN RIVERDALE, COUNTY P.G.C., STATE Md.			
24 FUNERAL DIRECTOR NAME W. W. CHAMBERS CO. INC.				25. DATE REC'D. BY REGISTRAR 20910 SILVER SPRING, Md. OCT 30 1987					
25b REGISTRAR'S SIGNATURE <u>Julia Parker-Budner</u>									

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP _____

DHMH - 16 60M 7/B4
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be buried with the deceased within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

070488 NOV-5 81

RECEIVED

NOV 5 1981

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4-87 OR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)		2a DATE OF DEATH MONTH DAY YEAR		2b HOUR	
WILLIAM OFFENBACHER		October 6 1987		10:40 P.M.	
3 SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS (LAST BIRTHDAY)) YRS.	7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Male	Caucasian	10 29 35	51		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH		
Washington, D.C.	US		Prince George's MD.		
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b INDUSTRY	
Langham	Doctors' Hospital of Pr. Geo. Co		Reproduction	Teamsters	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS / ZIP CODE	
Md.	P.G.	Greenbelt		43-E Ridge Road 20770	
14 FATHER'S NAME FIRST MIDDLE LAST			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		
Adam Offenbacher			Alice Williams		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b SOCIAL SECURITY NO.	17 INFORMANT	18 ADDRESS	
At 1 Guard Unknown		578-44-8944	Alice Hanks	14902 Nalmia Drive Laurel, Md. 20707	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE CARDIO PULMONARY ARREST					
DUE TO, OR AS A CONSEQUENCE OF PROBABLE ACUTE					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
DUE TO, OR AS A CONSEQUENCE OF MYOCARDIAL INFARCTION					
PULMONARY EMBOLISM					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1					
DIABETES CHRONIC OBSTRUCTIVE LUNG DISEASE					
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 10/6 1987 to 10/6 1987 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE A. RAO	DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c DATE SIGNED 10/7/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) A. RAO	22e ADDRESS				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 10/9/87	23c NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d LOCATION Washington, D.C.		
24 FUNERAL DIRECTOR NAME ADDRESS Fleck Funeral Home, Inc. Laurel, Md. 20707		25a DATE RECD BY REGISTRAR OCT 13 1987			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

RELEASED TO PMD BY MEDICAL EXAMINER

BP

DHMH - 16 60M 7, 84
(VRA 15, 4)

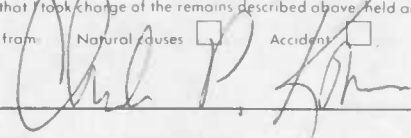
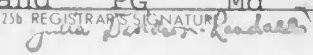
06-87 930 882-880

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68243 OCT -9-87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

30424
REG NO.

1- STATE REGISTRAR DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST James Michael Oliver										2a DATE KNOWN OF DEATH ESTI MATED <input checked="" type="checkbox"/> 10/ 4/ 19 87		2b HOUR 2:17 a m					
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Oct 27 1956		6 AGE (IN YEARS) (LAST BIRTHDAY) 30 RS		IF UNDER 1 YR IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD MONTH DAY YEAR 10/ 4/ 1987		2d HOUR 2:17 a m					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC				7b CITIZEN OF WHAT COUNTRY? USA				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD					
10 CITY OR TOWN OF DEATH Cheverly				11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Prince George's General Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter				12b KIND OF BUSINESS OR INDUSTRY construction					
13a STATE Maryland										13b COUNTY Pr George		13c CITY OR TOWN Capitol Hts		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 5310 Cumberland St. 20743	
14 FATHER'S NAME FIRST MIDDLE LAST Thomas Russell Talbert				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Ollie Talbert													
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) Yes Vietnam				16b SOCIAL SECURITY NO. 215-64-5103				17 INFORMANT Preston E Talbert				ADDRESS 8007 Daniel Dr Forestville, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gunshot Wound of Abdomen with Complications Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last } b) DUE TO, OR AS A CONSEQUENCE OF c) DUE TO, OR AS A CONSEQUENCE OF														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I																	
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?								20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7:24am 9/ 28/ 19 87				21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM #B PART I OR PART 2) subject shot									
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.) resident at				21f LOCATION CITY OR TOWN STREET 7314 Landover Rd., Landover, Pr. Geo., Md. COUNTY STATE									
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE 				TITLE (SPECIFY) Assistant				MEDICAL EXAMINER				DATE SIGNED 10/4/87					
EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201													
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b DATE 10-7-87		23c NAME OF CEMETERY OR CREMATORY Washington National				23d LOCATION CITY OR TOWN Suitland PG MD							
24 FUNERAL DIRECTOR NAME Robert E Wilhelm				ADDRESS Suitland, Md.				25a DATE REC'D BY REGISTRAR OCT 8 1987				25b REGISTRAR'S SIGNATURE 					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM "FM-3". RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

8853 OCT-901

100% COTTON
MADE IN
CHINA



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- STATE
REGISTRAR

DECEASED NAME

FIRST

MIDDLE

LAST

Merrill Thomas Osborne, Jr.

2a DATE KNOWN
OF ESTI-
DEATH MATED

MONTH DAY YEAR
10-30 1987

7b HOUR
M

3 SEX

Male

4 RACE

Black

5 DATE OF BIRTH

May 19 1963

6 AGE (IN YEARS)

24 YRS.

IF UNDER 1 YR

IF UNDER 24 HRS

7c DATE
PRONOUNCED
DEAD

MONTH DAY YEAR
10-30- 19 87

7d HOUR
4:06
P M

7a BIRTHPLACE (STATE OR
FOREIGN COUNTRY)

Virginia

7b CITIZEN OF WHAT COUNTRY?

U.S.A.

8 MARRIED ☐ NEVER MARRIED ☒
WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Prince George's County MD

10 CITY OR TOWN OF DEATH

Cheverly

11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Prince George's General Hospital

12a USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)

Plumber

12b KIND OF BUSINESS
OR INDUSTRY

Private

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

MD

13b COUNTY

PG

13c CITY OR TOWN

Landover

13d INSIDE CITY LIMITS?

YES ☒ NO ☐

13e STREET ADDRESS

2107 Vermont Avenue

14 FATHER'S NAME

Merrill

MIDDLE

Thomas

LAST

Osborne, Sr. Wilma

15 MOTHER'S MAIDEN NAME

MIDDLE

M.

Moore

16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)

No

16b SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)

N/A

218-92-9666

17 INFORMANT

Wilma M. Osborne/2107 Vermont Ave

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Multiple injuries

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last

(b) DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED?

20 AUTOPSY?

YES ☒ NO ☐

21a EXTERNAL CAUSE WAS
UNDERLYING ☒ OR
CONTRIBUTING ☐ CAUSE OF DEATH

21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
2:55 PM 10-30-87

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18B PART I OR PART 2)

Subject fell through skylight at work

21d INJURY OCCURRED
WHILE ☒ NOT WHILE ☐
AT WORK AT WORK

21e PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)
roof

21f LOCATION
STREET CITY OR TOWN COUNTY STATE

6850 Distribution Drive, Beltsville, Prince
George's Co., MD

22a I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion
death resulted from Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE

TITLE (SPECIFY)

M.D. Deputy Chief

DATE
SIGNED 10-31-87

EXAMINER'S NAME
(TYPE OR PRINT)

Ann M. Dixon, M.D.

ADDRESS 111 Penn St., Baltimore, MD 21201

23a BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b DATE

Nov 7, 1987

23c NAME OF CEMETERY OR CREMATORY

Harmony

23d LOCATION
CITY OR TOWN

Landover

COUNTY

PG

STATE

MD.

24 FUNERAL DIRECTOR

J.B. JENKINS/7474 LANDOVER RD/LANDOVER

25a DATE REC'D. BY REGISTRAR

NOV 6 1987

25b REGISTRAR'S SIGNATURE

Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2 AND 3 TO THE FUNERAL DIRECTOR
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM, PM 3. RETAIN PAGE 5 FOR YOUR FILES
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

51580 10A-045

100

20X COTTON 1000

WILSON

068958 OCT 20 1987

STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

30426

1 DECEASED NAME (TYPE OR PRINT) ALBERT (Joseph) J. PEARMON			2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH 10 DAY 10 YEAR 1987			2b HOUR M		
3 SEX Male	4 RACE Black	5 DATE OF BIRTH MONTH 07 DAY 03 YEAR 40	6 AGE (IN YEARS) (LAST BIRTHDAY) 47 YRS.	IF UNDER 1 YR MONTHS XX DAYS XX	IF UNDER 24 HRS HOURS XX MIN XX	2c DATE PRONOUNCED DEAD MONTH 10 DAY 10 YEAR 1987		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's County			11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Central Ave. so. of Capital Beltway			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SAA		
13a STATE Maryland			13b COUNTY Prince Geo			13c CITY OR TOWN Upper Marl.		
14 FATHER'S NAME FIRST William MIDDLE Henry LAST Pearmon			15 MOTHER'S MAIDEN NAME FIRST Alma MIDDLE Henrietta LAST Tucker			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b SOCIAL SECURITY NO. 214 38 2518			17 INFORMANT ADDRESS 4914 Woodford Ln. 20772		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Head injuries Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4:10xx 10-10- 1987			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Driver of pick-up truck that lost control.		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road			21f LOCATION STREET Central Ave. so. of Capital Beltway, CITY OR TOWN Prince George's COUNTY MD STATE MD		
22a I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Mario F. Golle, Jr.			TITLE (SPECIFY) Assistant			DATE SIGNED 10-10-87		
EXAMINER'S NAME (TYPE OR PRINT) Mario F. Golle, Jr., M.D.			ADDRESS 111 Penn St., Balto., MD 21201					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 15 Oct 87			23c NAME OF CEMETERY OR CREMATORY Harmony Mem. Garden		
24 FUNERAL DIRECTOR Martell Adams			ADDRESS Aguasco Ind 20608			23d LOCATION CITY OR TOWN Landover, P.G. Co., MD COUNTY MD STATE MD		
25a DATE REC'D. BY REGISTRAR OCT 19 1987			25b REGISTRAR'S SIGNATURE John Davidson-Randall					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 18, 19, AND 20 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-4 WITHIN 10 DAYS OF YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD, 21201

07/84
25MBP
DHMH: 17
(VR A15 ME (5))

068820 001 50 03

UNITED STATES
NAVY
OFFICE



4

United States Navy

7
J71274 NOV 0 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 30427
REG NO

FOR
1- STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST MIDDLE LAST
William L. PERRY

2a. DATE OF DEATH MONTH DAY YEAR 10-28-87
2b. HOUR 12:25 PM

3 SEX

Male

4 RACE

Cauc

5 DATE OF BIRTH

MONTH DAY YEAR 1 16 1913

6 AGE (IN YEARS LAST BIRTHDAY)

74

IF UNDER 1 YEAR

IF UNDER 24 HRS

7a BIRTHPLACE

COUNTRY STATE OR FOREIGN
Pittsburg, Pa.

7b CITIZEN OF WHAT COUNTRY?

U.S.

MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

P.G.

MD

10 CITY OR TOWN OF DEATH

LARGO

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
MANOR CARE LARGO HEALTH CARE, REST. MANAGER

12a USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE)
CARE, REST. MANAGER

12b KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

Md.

13b COUNTY

P.G.

13c CITY OR TOWN

BOWIE

13d INSIDE CITY LIMITS?

YES ☐ NO ☐

13e STREET ADDRESS / ZIP CODE

3909 NEW HAVEN CT B6 20715

14 FATHER'S NAME

FIRST MIDDLE LAST
Michael Gillati PERRY

15 MOTHER'S MAIDEN NAME

FIRST MIDDLE LAST
UNKNOWN

16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)

(IF YES, GIVE WAR OR DATES)

16b SOCIAL SECURITY NO.

578-04-0561

17 INFORMANT

MABLE PERRY - wife - s/a

18 CAUSE OF DEATH Enter only one cause per line for 10a, b, and c.
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE 10a

Cardio - Pulmonary Arrest

DUE TO OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause 10a stating the underlying cause last

10b Metastatic Carcinoma of Bladder

DUE TO OR AS A CONSEQUENCE OF

10c Prostate and Lymphoma

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 10a

Anemia, ileostomy bag, Hematuria

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

YES ☐ NO ☐

20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐

21a ACCIDENT WAS UNDERLYING

21b TIME OF INJURY

CAUSE OF DEATH HOUR A.M. MONTH DAY YEAR
P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART 2 OF PART 2)

21d INJURY OCCURRED

21e PLACE OF INJURY

(A) HOME (B) STREET (C) FACTORY (D) OFFICE (E) FARM (F) OTHER

21f LOCATION

(STREET)

(CITY OR TOWN)

COUNTY

STATE

22a I certify that (I) (this hospital) attended the deceased from 8-1 19 87 to 10-28 19 87 that (I) (we) last saw the deceased alive on 10-28 - 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death

22b SIGNATURE

Rakesh Chandra

DEGREE

M.D.

ATTENDING PHYSICIAN ☒

MEDICAL DIRECTOR ☐

STAFF PHYSICIAN ☐

22c DATE SIGNED

10/28

22d PHYSICIAN'S NAME (TYPE OR PRINT)

RAKESH AROFA

22e ADDRESS

14300 GALLANT FOX LN. BOWIE, MD 20715

23a BURIAL, CREMATION, REMOVAL (SPECIFY)

Removal

23b DATE

10-28-87

23c NAME OF CEMETERY OR CREMATORY

23d LOCATION

CITY OR TOWN

COUNTY

STATE

24 FUNERAL DIRECTOR

NAME

State Anatomy Board

ADDRESS

Balto., Md.

25a DATE REC'D BY REGISTRAR

NOV 02 1987

25b REGISTRAR'S SIGNATURE

Julia Tindon-Rudman

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These instructions are on the back of the certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. (Special request: IMPORTANT! If item 21 is marked or item 18 shows any injury, another hospital event, the medical investigation must be notified.)

070401

FOR
STATE
REGISTER

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

30428
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Kelso Juanita Phillips			2a DATE KNOWN OF DEATH MONTH DAY YEAR 10-26-87			2b HOUR M		
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR 1-4-16	6 AGE (IN YEARS) (LAST BIRTHDAY) 71 YRS.	IF UNDER 1 YR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD MONTH DAY YEAR 10-26-87		2d HOUR M
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD		
10 CITY OR TOWN OF DEATH Andrews A.F.B.		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Andrews A.F.B. - Malcolm (Grass)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY Home
13a STATE Maryland			13b COUNTY Pr. Georges	13c CITY OR TOWN Upper Marlboro	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS 9110 Dandelion Lane 20772		
14 FATHER'S NAME FIRST MIDDLE LAST Herbert E. Harler				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Easton				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b SOCIAL SECURITY NO. 577-44-1067		17 INFORMANT ADDRESS Charles E. Phillips 1101 Fairbanks Ct. Waldorf, Md. 20601			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE Diabetic autonephroses Cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last diabetes DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?					20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE Augusto P. Rodriguez			TITLE (SPECIFY) Deputy			DATE SIGNED 10-26-87		
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.			ADDRESS 5009 Rayburn Ct., Temple Hills, MD					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 10-29-87		23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. Md.	
24 FUNERAL DIRECTOR NAME G.P. Kalas F.H.			ADDRESS 6160 Oxon Hill Rd. Oxon Hill, Md.			25a DATE REC'D. BY REGISTRAR OCT 30 1987		25b REGISTRAR'S SIGNATURE Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM RM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07 84
25MBP
DHMH - 17
(VR A15 ME (5))

0613 NOV -3 87
70613

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EUGENE POWELL		2a DATE OF DEATH MONTH DAY YEAR 10 29 87		2b HOUR 4:40 AM	
3 SEX MALE		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 07 20 12	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b CITIZEN OF WHAT COUNTRY? USA		6 AGE (IN YEARS LAST BIRTHDAY) 75 YRS	
10 CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY GIVE STREET ADDRESS) So. Maryland Hospital		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES CO MD	
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Postal Clerk		12b KIND OF BUSINESS OR INDUSTRY U S Gov't		13a STREET ADDRESS / ZIP CODE 1819 Que Street SE 99999	
14 FATHER'S NAME FIRST MIDDLE LAST Powell		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	
16b SOCIAL SECURITY NO. 579-05-3374		17 INFORMANT ADDRESS 2027 36th St SE		18 CAUSE OF DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Thrombotic thrombocytopenic purpura DUE TO, OR AS A CONSEQUENCE OF Vaccination Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Renal failure - mild					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 2 OR PART 3)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NO <input type="checkbox"/> WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22 I certify that (I) (this hospital) attended the deceased from September 19 87 to October 28 19 87 that (I) (we) last saw the deceased alive on October 28 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) sign the body after death.					
22a SIGNATURE Rene Grace MD		DEGREE MD		22c DATE SIGNED 29 Oct 87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Rene Grace MD		22e ADDRESS 9131 Piscataway Rd Clinton			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 31 Oct 1987		23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
23d LOCATION CITY OR TOWN COUNTY STATE Suitland PG Md		24 FUNERAL DIRECTOR NAME ADDRESS Robert E Wilhelm Funeral Home Suit land Md			
25a DATE REC'D. BY REGISTRAR NOV 2 1987		25b REGISTRAR'S SIGNATURE John Stetson-Randall			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and place them in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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Handwritten text, mostly illegible due to bleed-through from the reverse side. The text appears to be organized into several paragraphs or sections, with some lines being underlined. The handwriting is cursive and somewhat faded.

2

068651 OCT 15 1987

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 7 3 0 4 3 0

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Frederick Jerome Proctor			2a DATE OF DEATH MONTH DAY YEAR 10 8 87		2b HOUR 10 20 AM
3 SEX Male	4 RACE Black	5 DATE OF BIRTH MONTH DAY YEAR Oct. 4 1941		6 AGE (IN YEARS LAST BIRTHDAY) 46	7 UNDER 1 YEAR 8 UNDER 2 YEARS 9 UNDER 3 YEARS 10 UNDER 4 YEARS 11 UNDER 5 YEARS 12 UNDER 6 YEARS 13 UNDER 7 YEARS 14 UNDER 8 YEARS 15 UNDER 9 YEARS 16 UNDER 10 YEARS 17 UNDER 11 YEARS 18 UNDER 12 YEARS 19 UNDER 13 YEARS 20 UNDER 14 YEARS 21 UNDER 15 YEARS 22 UNDER 16 YEARS 23 UNDER 17 YEARS 24 UNDER 18 YEARS 25 UNDER 19 YEARS 26 UNDER 20 YEARS 27 UNDER 21 YEARS 28 UNDER 22 YEARS 29 UNDER 23 YEARS 30 UNDER 24 YEARS 31 UNDER 25 YEARS 32 UNDER 26 YEARS 33 UNDER 27 YEARS 34 UNDER 28 YEARS 35 UNDER 29 YEARS 36 UNDER 30 YEARS 37 UNDER 31 YEARS 38 UNDER 32 YEARS 39 UNDER 33 YEARS 40 UNDER 34 YEARS 41 UNDER 35 YEARS 42 UNDER 36 YEARS 43 UNDER 37 YEARS 44 UNDER 38 YEARS 45 UNDER 39 YEARS 46 UNDER 40 YEARS 47 UNDER 41 YEARS 48 UNDER 42 YEARS 49 UNDER 43 YEARS 50 UNDER 44 YEARS 51 UNDER 45 YEARS 52 UNDER 46 YEARS 53 UNDER 47 YEARS 54 UNDER 48 YEARS 55 UNDER 49 YEARS 56 UNDER 50 YEARS 57 UNDER 51 YEARS 58 UNDER 52 YEARS 59 UNDER 53 YEARS 60 UNDER 54 YEARS 61 UNDER 55 YEARS 62 UNDER 56 YEARS 63 UNDER 57 YEARS 64 UNDER 58 YEARS 65 UNDER 59 YEARS 66 UNDER 60 YEARS 67 UNDER 61 YEARS 68 UNDER 62 YEARS 69 UNDER 63 YEARS 70 UNDER 64 YEARS 71 UNDER 65 YEARS 72 UNDER 66 YEARS 73 UNDER 67 YEARS 74 UNDER 68 YEARS 75 UNDER 69 YEARS 76 UNDER 70 YEARS 77 UNDER 71 YEARS 78 UNDER 72 YEARS 79 UNDER 73 YEARS 80 UNDER 74 YEARS 81 UNDER 75 YEARS 82 UNDER 76 YEARS 83 UNDER 77 YEARS 84 UNDER 78 YEARS 85 UNDER 79 YEARS 86 UNDER 80 YEARS 87 UNDER 81 YEARS 88 UNDER 82 YEARS 89 UNDER 83 YEARS 90 UNDER 84 YEARS 91 UNDER 85 YEARS 92 UNDER 86 YEARS 93 UNDER 87 YEARS 94 UNDER 88 YEARS 95 UNDER 89 YEARS 96 UNDER 90 YEARS 97 UNDER 91 YEARS 98 UNDER 92 YEARS 99 UNDER 93 YEARS 100 UNDER 94 YEARS 101 UNDER 95 YEARS 102 UNDER 96 YEARS 103 UNDER 97 YEARS 104 UNDER 98 YEARS 105 UNDER 99 YEARS 106 UNDER 100 YEARS
9a BIRTHPLACE (COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES CO. MD	
10 CITY OR TOWN OF DEATH CLINTON		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern MD Hospital Center		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) clerk	
13a STATE Maryland		13b COUNTY Pr. George's		13c CITY OR TOWN Clinton	
14 FATHER'S NAME FIRST MIDDLE LAST John Alvin Proctor		15 MOTHER'S MAIDEN NAME MIDDLE LAST Mary B.		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes	
16b SOCIAL SECURITY NO 1959-1962		17 INFORMANT Lisa Brown		18 ADDRESS 4413 Rena Rd. Forestville, MD 20746	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio Pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) Metastatic Carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes 1 year					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I Asthma					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY, PHYSICAL OR PART OF PART II)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22 I certify that (I) the hospital attended the deceased from 10/7 1987 to 10/8 1987 that (I) last saw the deceased alive on 10/7 1987 and that in my opinion death occurred on the date and hour and from the causes stated					
22b SIGNATURE Louis Kaufman		22c ADDRESS 8926 Woodmont Rd Clinton		22d DATE SIGNED 10/9/87	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Oct. 13, 1987		23c NAME OF CEMETERY OR CREMATORY Resurrection Cem.	
23d LOCATION (CITY OR TOWN) Clinton, P.G.,		23e COUNTY P.G.		23f STATE MD	
24 FUNERAL DIRECTOR NAME Lee Funeral Home, Inc. Old Alexander Ferry Rd., Clinton, MD 20735		25a DATE REC'D. BY REGISTRAR OCT 14 1987		25b REGISTRAR'S SIGNATURE Julia Gordon-Randall	

BP

DHMH - 16 60M 7 84
(VRA 15, 4)

16633

Division of Vital Records, 201 W. Preston St., Baltimore, Maryland 21201

Released by Dr. Rodriguez

TO HOSPITAL OR ATTENDING PHYSICIAN: The physician certifying the death must be a physician who is licensed to practice medicine in the State of Maryland and who is not the attending physician of the deceased.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

000001 OCT 1907



071084 NOV-98

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (IF OR PRINT)			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR A M		
Mary Irene Proctor			10/28/87			0935 ^A		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?
Female	Black	01/22/05		82 YRS		Maryland		USA
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
Maryland			USA			9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.		
10. CITY OR TOWN OF DEATH CLINTON			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hosp. Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. STREET ADDRESS / ZIP CODE		
13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Charles Waldorf			Box 193 A Davis Road 20601		
14. FATHER'S NAME FIRST MIDDLE LAST George Washington Proctor			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Regina Thompson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 218 74 1665		17. INFORMANT Jean Pickeral SAA	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Extensive Heart attack</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) <u>Cancer + Cancer of Neck lymph</u> DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE 935 ^A			
22a. I certify that (I) (this hospital) attended the deceased from <u>10/28/87</u> to <u>10/28/87</u> that (I) (we) last saw the deceased alive on <u>above</u> (b) (we) (did) (did not) view the body after death							
22b. SIGNATURE <u>MOASSER N M.D.</u>				DEGREE M.D.		22c. DATE SIGNED <u>10/28/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>MOASSER N M.D.</u>				22e. ADDRESS <u>Slaid by MED Clinic</u> <u>Brandenburg</u> <u>tel 3226400</u>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2 Nov 87		23c. NAME OF CEMETERY OR CREMATORY St Ignatius Ch Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Oxon Hill, P.G. Co., MD	
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24. FUNERAL DIRECTOR NAME ADDRESS <u>Marcell Adams, Aquasco Md 20608</u>		DATE REC'D BY REGISTRAR NOV 06 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
--	--	--	--	--	--

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital, attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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070818 NOV 5 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO 30432

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GEORGE R. PYLE		2a. DATE OF DEATH MONTH DAY YEAR 10-30-87		2b. HOUR 10 30AM M	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Feb. 13, 1921	
6. AGE (IN YEARS LAST BIRTHDAY) 66		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina		7b. CITIZEN OF WHAT COUNTRY? United States	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S County, MD			
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S HOSPITAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Military	
12b. KIND OF BUSINESS OR INDUSTRY US Government		13a. STATE Maryland		13b. COUNTY Pr. George's	
13c. CITY OR TOWN Bowie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 12631 Kornett Lane 20715	
14. FATHER'S NAME FIRST MIDDLE LAST Louis Frederick Pyle		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Murray			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Carreer 225-46-7536		17. INFORMANT ADDRESS 12631 Kornett Lane Harriett H. Pyle Bowie, MD 20715	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cordiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Reheumatic heart disease</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (a) <u>Chronic Renal Failure</u> <u>Chronic obstructive Lung disease</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <u>Nov 26</u> , 19 <u>84</u> , to <u>30th Oct</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>Oct 30</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Rishpal Singh</u>		DEGREE <u>MD MRCP</u>		22c. DATE SIGNED <u>10-30-87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>RISHPAL SINGH</u>		22e. ADDRESS <u>7525 Greenway Center Drive Greenbelt, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>NOV 3, 1987</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem Arlington, Virginia</u>	
23d. LOCATION CITY OR TOWN COUNTY STATE <u>Bowie, MD 20715-3043</u>		23e. DATE REC'D. BY REGISTRAR <u>NOV 04 1987</u>		23f. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

01001010050

0070235 OCT 29 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

30433

REG NO

FOR
1- STATE
REGISTRAR

DECEASED NAME

FIRST

MIDDLE

LAST

(TYPE OR PRINT)

Leonard

Pyles

2a DATE KNOWN OF DEATH ☒ ESTI. ☐ MATED ☐ 10 25 19 87 7b HOUR M

3 SEX MALE 4 RACE BLACK 5 DATE OF BIRTH MONTH DAY YEAR 8 9 63 6 AGE (IN YEARS) (LAST BIRTHDAY) 24 YRS. 7a CITIZEN OF WHAT COUNTRY? U.S.A. 8 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ 9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD

10 CITY OR TOWN OF DEATH Cheverly 11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hospital 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b KIND OF BUSINESS OR INDUSTRY

13a STATE MARYLAND 13b COUNTY PG 13c CITY OR TOWN SILVER SPRING 13d INSIDE CITY LIMITS? ☒ YES ☐ NO 13e STREET ADDRESS 1927 EASTWEST HIGHWAY 20910

14 FATHER'S NAME FIRST MIDDLE LAST LESLIE PYLES 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BELVYN HARDY

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) UNKNOWN 16b SOCIAL SECURITY NO. UNAVAILABLE 17 INFORMANT ADDRESS BELVYN HARDY PYLES-1927 E. W HIGHW

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gunshot wound of head
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a DATE OF OPERATION 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? 20 AUTOPSY? YES ☒ NO ☐

21a EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1 xx 10 25 19 87 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Subject shot

21d INJURY OCCURRED WHILE ☐ NOT WHILE ☒ AT WORK ☐ AT WORK 21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.) house 21f LOCATION STREET CITY OR TOWN COUNTY STATE 1427 9th St. Glen Arden, P.G., MD

22a I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE *Dennis F. Smyth* TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 10/25/87

EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. ADDRESS 111 Penn St. Balto.MD.

23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL 23b DATE 10-28-87 23c NAME OF CEMETERY OR CREMATORY WASH. NATIONAL CEME. SUTTLAND, MARYLAND 23d LOCATION (CITY OR TOWN) COUNTY STATE

24 FUNERAL DIRECTOR NAME *W.H. Bacon* ADDRESS W.H. BACON FUNERAL HOME, 3447 14TH D.C. 25a DATE REC'D BY REGISTRAR OCT 28 1987 25b REGISTRAR SIGNATURE *[Signature]*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. BALTIMORE STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP

DHMM - 17
(VR A15 ME (5))

07033 001 001

20% COTTON FIBER

CHIEFMAN BRAND



001 38 001 3 001 38 001

068168 OCT-87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

30434

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)		FIRST <i>Joseph</i>		MIDDLE <i>S.</i>		LAST <i>Quinitchette</i>		2a DATE KNOWN OF DEATH ESTI MATED <input type="checkbox"/> 10-6-87		2b HOUR M	
3 SEX <i>Male</i>	4 RACE <i>BLACK</i>	5 DATE OF BIRTH MONTH DAY YEAR <i>MAY 4, 1956</i>		6 AGE (IN YEARS) (LAST BIRTHDAY) <i>31 YRS.</i>		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c DATE PRONOUNCED DEAD MONTH DAY YEAR <i>10-6-87</i>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>NEW YORK</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>P.G.</i>		MD			
10 CITY OR TOWN OF DEATH <i>CHEVERLY</i>		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Prime Care General Hospital</i>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>PROGRAM ASSIST</i>		12b KIND OF BUSINESS OR INDUSTRY <i>PRIVATE</i>					
13a STATE <i>MARYLAND</i>		13b COUNTY <i>P.G.</i>		13c CITY OR TOWN <i>LANDOVER</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <i>1806 DUTCH VILLAGE DR.</i>		<i>20784</i>	
14 FATHER'S NAME FIRST MIDDLE LAST <i>JOSEPH QUINITCHETTE</i>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>UNKNOWN</i>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>NO</i>		16b SOCIAL SECURITY NO. <i>n/a</i>		17 INFORMANT <i>LANDOVER MARYLAND</i>			
18 CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last <i>Acquired Immunity Deficiency Syndrome</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <i>Emaciated</i>											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>		TITLE (SPECIFY) <i>Deputy</i>		M.D.		MEDICAL EXAMINER		DATE SIGNED <i>10-6-87</i>			
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez, M.D.</i>		ADDRESS <i>5009 Rayburn Ct., Temple Hills, MD</i>									
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b DATE <i>10-10-87</i>		23c NAME OF CEMETERY OR CREMATORY <i>HARMONY MEMORIAL PK.</i>		23d LOCATION CITY OR TOWN COUNTY STATE <i>LANDOVER MARYLAND</i>		24 FUNERAL DIRECTOR NAME ADDRESS <i>J.B. JENKINS FUNERAL HOME 7474 LANDOVER RD. LANDOVER, MD.</i>		25a DATE REC'D. BY REGISTRAR <i>OCT-8 1987</i>	
						25b REGISTRAR'S SIGNATURE <i>Julia Davidson-Lindner</i>					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07-84
25M

BP
DHMH-17
(VR A15 ME (5))

000188 OCT-87



Handwritten signature or name, possibly "James P. [unclear]"

20% COTTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copiers. Pages 1 and 2 should be mailed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR

REG. NO.

2. DECEASED NAME (TYPE OR PRINT) Ganga Devi RAMAMURTY			2a. DATE OF DEATH MONTH DAY YEAR October 30, 1987		2b. HOUR 3:53 P.M.
3. SEX Female	4. RACE East Indian	5. DATE OF BIRTH MONTH DAY YEAR June 14, 1925	6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) India	7b. CITIZEN OF WHAT COUNTRY? India	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.		
10. CITY OR TOWN OF DEATH Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctor's Hospital of P.G. County		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland			13b. COUNTY P.G. Co.	13c. CITY OR TOWN Lanham	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST C. - Shankar			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alamelu - (N/A)		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) None	17. INFORMANT ADDRESS 8605 Aqueduct Road Potomac, Maryland 20854		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>fracture, MI</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (a) <u>D.M.</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/30/87</u> 19 <u>87</u> to <u>10/30/87</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>10/30/87</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Dr. M. G. Hosh</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/31/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. G. HOSH M.D.		22e. ADDRESS 6510 KENILWORTH AVE, SUITE 1404 RIVERDALE, MD 20737			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Oct/31/87	23c. NAME OF CEMETERY OR CREMATORY Chambers Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Riverdale, P.G. Co., Maryland
24. FUNERAL DIRECTOR NAME W. W. Chambers Co., Inc.		ADDRESS Riverdale, Maryland		25a. DATE REC'D. BY REGISTRAR NOV 5 1987	25b. REGISTRAR'S SIGNATURE <u>John D. ...</u>

BP _____

70-8-101 11015

068876 OCT 1987

OR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SUSIE T. RANDOLPH			2a. DATE OF DEATH MONTH DAY YEAR 10 15 87		2b. HOUR 11:00 AM	
3. SEX FEMALE		4 RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR OCT. 1, 1931		
7a BIRTHPLACE (STATE OR FOREIGN) NORTH CAROLINA		7b CITIZEN OF WHAT COUNTRY? UNITED STATES		8. AGE (IN YEARS LAST BIRTHDAY) 56		
10 CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD		
13a STATE MARYLAND		13b COUNTY PRINCE GEO.		13c CITY OR TOWN TEMPLE HILL		
14 FATHER'S NAME FIRST MIDDLE LAST FRANK THORNE		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BETTIE MOORE		12a USUAL OCCUPATION (1) PRESENT (2) MOST OF WORKING LIFE HOUSEWIFE		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b SOCIAL SECURITY NO. 578 52 5219		17 INFORMANT HUSBAND ADDRESS JAMES RANDOLPH-3209 Dallas Dr. Temple Hill, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hepatic Encephalopathy</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) <u>CIRRHOSIS of liver</u>						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>congestive heart failure, renal failure sepsis, ascites GI bleed GU bleed</u>						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from <u>Sept. 24</u> 19 <u>87</u> to <u>Oct 15</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>Oct 15</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b SIGNATURE <u>Helen Capone</u>				22c DATE SIGNED OCT 15-87		
22d PHYSICIAN'S NAME (TYPE OR PRINT) HELEN CAPONE MD				22e ADDRESS 7501 SURREATTS RD #105 CLINTON MARYLAND 20735		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE 10/20/87		23c NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		
23d LOCATION CITY OR TOWN COUNTY STATE SUITLAND PG MARYLAND		23e DATE REC'D BY REGISTRAR OCT 16 1987		23f REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>		
24 FUNERAL DIRECTOR NAME ADDRESS ALEXANDER S. POPE 2617 Pa Ave SE DC						

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP _____

DHMH 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

060810 OCT 1981

31222

060810

060810

071310 NOV 10 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

30437

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Rankin			2a DATE OF DEATH MONTH DAY YEAR September 4, 1987		2b HOUR 1:49P M	
3 SEX Male		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR Sept. 4, 1987		
6 AGE (IN YEARS LAST BIRTHDAY) Newborn		7b CITIZEN OF WHAT COUNTRY? Maryland		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's		10 CITY OR TOWN OF DEATH Cheverly		
11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's Hospital Center		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		12b KIND OF BUSINESS OR INDUSTRY None		
13a STATE Maryland		13b COUNTY PG		13c CITY OR TOWN Landover		
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Tyra Denean Rankin		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) No		
16b SOCIAL SECURITY NO. None		17 INFORMANT ASTHIA NEWATOWN		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Extreme prematurity DUE TO, OR AS A CONSEQUENCE OF (b) Complete abortion DUE TO, OR AS A CONSEQUENCE OF (c) ABORTIO RUPTA						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9/4/87		
21c INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21d PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21e HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
22a I certify that (1) (this hospital) attended the deceased from 9/4/87 to 9/4/87 that I (we) last saw the deceased alive on 9/4/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.						
22b SIGNATURE Steele P. Warner MD		DEGREE MD		22c DATE SIGNED 9/4/87		
22d PHYSICIAN'S NAME (TYPE OR PRINT) Steele P. Warner		22e ADDRESS Prince Georges Hosp Center, Chevy Chase, MD		23a BURIAL, CREMATION, REMOVAL (SPECIFY)		
23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE		
24 FUNERAL DIRECTOR NAME		ADDRESS		25 REGISTRAR'S SIGNATURE NOV 09 1987		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: MIDDLE: LAST: Rankine			2a. DATE OF DEATH MONTH: DAY: YEAR: Sept. 4, 1987		2b. HOUR 2:00P	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH: DAY: YEAR: Sept. 4, 1987		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? Maryland		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's Hospital Center		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD		
13a. STATE Maryland		13b. COUNTY PG		13c. CITY OR TOWN Landover		
14. FATHER'S NAME FIRST: MIDDLE: LAST:		15. MOTHER'S MAIDEN NAME FIRST: MIDDLE: LAST: Tyra Denean Rankin		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS: 1825 Village Green Dr. 21285		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ASPHYXIA ROUNDTOWN DUE TO, OR AS A CONSEQUENCE OF (b) ex treme Renal failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET: CITY OR TOWN: COUNTY: STATE:			
22a. I certify that (1) (this hospital) attended the deceased from 9/4/82 to 9/4/82 that (1) (we) last saw the deceased alive on 9/4/82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.							
22b. SIGNATURE STEVEN P. WYER				DEGREE MD		22c. DATE SIGNED 9/4/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS Prince Georges Hosp CTR, Cheverly MD			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN: COUNTY: STATE:	
24. FUNERAL DIRECTOR NAME: ADDRESS:				25a. DATE REC'D. BY REGISTRAR NOV 09 1987		25b. REGISTRAR'S SIGNATURE	

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068994 OCT 20 1987

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

2a DECEASED NAME (TYPE OR PRINT)			3 SEX			4 RACE			5 DATE OF BIRTH			6a DATE OF DEATH MONTH DAY YEAR			6b HOUR								
ETHEL W. RAWLINGS			Female			White			Dec. 12, 1908			9-22-87			5:34 P.M.								
7a BIRTHPLACE (STATE OR FOREIGN)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								
District of Columbia			U.S.A.						PRINCE GEORGE'S COUNTY MD			CLINTON			SOUTHERN MARYLAND HOSPITAL								
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY			13a STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
Clerk			Circuit Court			Maryland			Pr. Geo's			Port Washington			3703 Ladd Ave/20744								
14 FATHER'S NAME (FIRST MIDDLE LAST)			15 MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS								
Albert W. Wells			Lucy Ann Taylor			No						Yvonne M. Rawlings-Alexandria			4349 Lorcom Lane, Va. 22207								
18 CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) <u>Septic Shock, Ischemic Cardiomyopathy</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes Mellitus</u>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Admitted on 9/21/87 expired on 9/23/87 at 5:34 PM</u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>																							
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED						20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19						21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)														
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)						21f LOCATION (CITY OR TOWN COUNTY STATE)														
									Sept. 21 19 87 to Sept. 22, 19 87 that I (we) last saw the deceased alive on Sept. 22, 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22a I certify that (I) (this hospital) attended the deceased from Sept. 21, 19 87 to Sept. 22, 19 87												22c DATE SIGNED											
22b SIGNATURE <u>Satish Jomani</u> DEGREE <u>MD</u>												22e ADDRESS											
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>SATISH N. JOMANI</u>												22f ADDRESS <u>Clinton, Maryland</u>											
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (CITY OR TOWN COUNTY STATE)														
Burial			9/25/87			Mt. Carmel Cemetery			Upper Marlboro (Pr. Geo's) Md.														
24 FUNERAL DIRECTOR (NAME AND ADDRESS)												25a DATE RECEIVED BY REGISTRAR						25b REGISTRAR'S SIGNATURE					
Richard A. Coleman Upper Marlboro, Md. 20772												OCT 19 1987											

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

BP

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 069549 OCT 28 1987

1. DECEASED NAME (TYPE OR PRINT) Marie			FIRMS LOVING			MIDDLE RAY			LAST			2a. DATE OF DEATH MONTH 10 DAY 6 YEAR 87			2b. HOUR M		
3 SEX Female			4 RACE Black			5 DATE OF BIRTH MONTH 4 DAY 6 YEAR 1903			6 AGE (IN YEARS (LAST BIRTHDAY)) 84			7. UNDER 1 YEAR MONTH 10 DAY 6 YEAR 87			8. 1 YEAR OR OVER MONTH 10 DAY 6 YEAR 87		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's			MD					
10 CITY OR TOWN OF DEATH Clinton			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY N/A								
13a. STATE Maryland			13b. COUNTY P. George			13c. CITY OR TOWN Ft. Wash.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 500 Pine Road			20744		
14 FATHER'S NAME FIRST James MIDDLE L. LAST Loving			15 MOTHER'S MAIDEN NAME FIRST Mildred MIDDLE LAST Mead			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO 577-24-1096			17 INFORMANT Ann Glasgow			500 Pine Road Ft. Washington, Md.		
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE a. Coma DUE TO OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause a, stating the underlying cause last } b. Renal Insufficiency DUE TO OR AS A CONSEQUENCE OF c.																	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. Congestive Heart failure																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from 10-4 19 87 to 10-6 19 87 that (I) (we) last saw the deceased alive on 10-6 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Cyrus R. Parsey M.D.			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 10-8-87								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CYRUS R. PARSEY M.D.			22e. ADDRESS 8700 OLD BRANCH AVE CLINTON, MD. 20735														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/12/87			23c. NAME OF CEMETERY OR CREMATORY Lincoln Cemetary			23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. Md.								
24. FUNERAL DIRECTOR NAME J.B. JENKINS			7474 ADDRESS LANDOVER RD. LANDOVER, MD.			25a. DATE RECD BY REGISTRAR 11-22-1987			25b. REGISTRAR'S SIGNATURE								

BP

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069808 OCT 27 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

30441

1 DECEASED NAME (TYPE OR PRINT) Mildred Kathleen Reyno			2a DATE OF DEATH MONTH DAY YEAR October 20, 1987			2b HOUR AM PM 10:30 AM		
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR Sept 28, 1914		6 AGE (IN YEARS LAST BIRTHDAY) 73 YRS	7 UNDER 1 YEAR MONTHS DAYS 73		7c UNDER 72 HRS HOURS MIN 73	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Knoxville, Tenn		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				
10 CITY OR TOWN OF DEATH Temple Hills		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4503 Poppe Place			9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges			MD
12a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland		13b COUNTY Pr George		13c CITY OR TOWN Temple Hill		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 4503 Poppe Place 20748
14 FATHER'S NAME FIRST MIDDLE LAST William S Love			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lula Webb					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO 579-26-9791		17 INFORMANT Walter A Reyno		ADDRESS Same as #13		
18 CAUSE OF DEATH Enter only one cause per line for 18a, 18b, and 18c PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Breast Carcinoma								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 years
DUE TO OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								(b) _____ DUE TO OR AS A CONSEQUENCE OF (c) _____
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____								
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN REMARKS)				
21d INJURY OCCURRED FIRE <input type="checkbox"/> FLOOD <input type="checkbox"/> OTHER <input type="checkbox"/>		21e PLACE OF INJURY (IF HOME, GIVE STREET ADDRESS; IF OFFICE, GIVE OFFICE ADDRESS)		21f LOCATION (IF HOME, GIVE STREET ADDRESS; IF OFFICE, GIVE OFFICE ADDRESS)				
22a I certify that (1) (this hospital) attended the deceased from October 19 86 to 21 Oct 19 87 that (2) we last saw the deceased alive on March 19 87 and that in my own opinion death occurred on the date and hour and from the causes stated above (3) we (did) did not visit the body after death								
22b SIGNATURE Bernard M Keen mo (for Wm Oetgen)						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 21 Oct 87
22d PHYSICIAN'S NAME (TYPE OR PRINT) B Reen M.D.				22e ADDRESS 3611 Branch Ave Temple Hills, MD 20748				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 23 Oct 1987		23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Suitland PG Md		
24 FUNERAL DIRECTOR NAME Robert E. Wilhelm				ADDRESS Suitland, Md		25 DATED BY REGISTRAR 25b REGISTRAR'S SIGNATURE OCT 28 1987		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 8 shows any injury, or other traumatic event, the medical examiner should be notified at once.

BP

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

FOR
1- STATE
REGISTRAR

1 DECEASED NAME
(TYPE OR PRINT)

Ernest

Richards

2a DATE KNOWN OF DEATH ESTI- MATED ☒ 10/4 19 87

10687

Male

White

3 DATE OF BIRTH

May 27, 1919

6 AGE (IN YEARS)

68 YRS.

IF UNDER 1 YR

IF UNDER 24 HRS

2c DATE PRONOUNCED DEAD

10/9 19 87

10:10

A. M.

7a BIRTHPLACE

Massachusetts

7b CITIZEN OF WHAT COUNTRY?

U.S.A.

8 MARRIED

WIDOWED

NEVER MARRIED

DIVORCED

9 BALTIMORE CITY OR COUNTY OF DEATH

Prince George's County

10 CITY OR TOWN OF DEATH

Colmar Manor

11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

4213 Newton Street

12a USUAL OCCUPATION (TYPE OF WORK)

Mechanic

12b KIND OF BUSINESS OR INDUSTRY

Air Condit.

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

Maryland

13b COUNTY

Prince George's

13c CITY OR TOWN

Colmar Manor

13d INSIDE CITY LIMITS?

YES ☒ NO ☐

13e STREET ADDRESS

4213 Newton Street

14 FATHER'S NAME

ORAL

MIDDLE

CLARK

LAST

RICHARDS

15 MOTHER'S MAIDEN NAME

Anna

MIDDLE

Marie

LAST

Stockman

16a WAS DECEASED EVER IN U.S. ARMED FORCES?

Yes

No

(IF YES, GIVE WAR OR DATES)

WWII

16b SOCIAL SECURITY NO.

723-12-8277

17 INFORMANT P.O. Box 4156, Napa, Ca. 94558

Mrs. Carol A. Stahler, Daughter

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Acute myocardial disease

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

(b) chronic myocardial disease.

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

None

19a DATE OF OPERATION

None

19b CONDITION FOR WHICH OPERATION WAS PERFORMED?

20 AUTOPSY?

YES ☐ NO ☒

21a EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

None

21d INJURY OCCURRED

WHILE ☐ NOT WHILE ☐AT WORK ☐ AT WORK ☐

21e PLACE OF INJURY (AT HOME

STREET, FACTORY, FARM, ETC.)

21f LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☐ Inquiry ☒ and in my opinion

death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME

John S. Rogers, M.D.

M.D.

Deputy

MEDICAL EXAMINER

DATE SIGNED 10/9/87

1919 Seminary Road

Silver Spring, Montgomery County, MD

23a BURIAL, CREMATION, REMOVAL

Cremation

23b DATE

10-11-1987

23c NAME OF CEMETERY OR CREMATORY

Metropolitan Crematory

23d LOCATION

Alexandria,

COUNTY

Virginia

24 FUNERAL DIRECTOR

NAME

Francis Gasch's Sons, P.A.

4739 Baltimore Ave., Hyattsville, Maryland

25a DATE REC'D. BY REGISTRAR

OCT 14 1987

25b REGISTRAR'S SIGNATURE

John S. Rogers, M.D.

07 B4
25M

BP

DHMH - 17
(VR A15 ME (5))

06871 OCT 15 07

Male White

Present

Richard

7 10 57

10:10 10:10 10:10

Prince George's County

Miss Newton Street

Colman Street

Marple Prince George's County

Miss Newton Street

Acute myocardial disease

Chronic myocardial disease



None

None

None

John A. Rogers, M.D.

1019 Cemetery Road
Silver Spring, Montgomery County, MD

OCT 14 1957

067756 OCT-787

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

30443

1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			7a DATE KNOWN OF DEATH ESTIMATED			MONTH DAY YEAR			7b HOUR							
William Leroy Richards						10/ 3/ 87						M							
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE IN YEARS (LAST BIRTHDAY)		IF UNDER 1 YR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		7c DATE PRONOUNCED DEAD			7d HOUR				
Male		Cau.		Apr. 6, 1960		27 YRS						10/ 3/ 87			8:50 P M				
7a BIRTHPLACE (IF ABROAD, GIVE COUNTRY)				7b CITIZEN OF WHAT COUNTRY?				8 MARRIED WIDOWED				9 BALTIMORE CITY OR COUNTY OF DEATH							
Wash. D.C.				U.S.A.				NEVER MARRIED DIVORCED				Prince George's County, MD							
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b KIND OF BUSINESS OR INDUSTRY							
Cheverly				Prince George's General Hospital				Heavy Equip. Op				Self							
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																			
13a STATE				13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS									
Maryland				AA		Deale				801 Mason Ave. 20751									
14 FATHER'S NAME FIRST MIDDLE LAST								15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
Herbert Leroy Richards								Joy Elaine Marshall											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)								16b SOCIAL SECURITY NO.				17 INFORMANT ADDRESS							
NO								216-78-0010				Darlene R. Richards same as 13							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																			
PART I DEATH WAS CAUSED BY																			
IMMEDIATE CAUSE (a) Multiple Gunshot Wounds																			
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a) stating the under																			
lying cause last																			
DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																			
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?								20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY HOUR MIN MONTH DAY YEAR				21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
8:20 P.M. 10/ 3/ 87								subject shot											
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)				21f LOCATION CITY OR TOWN COUNTY STATE											
				on street				7300 Blk. Landover Rd., Pr. Geo. Co., Md.											
22a I certify that I took charge of the remains described above, held on																			
Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																			
death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED											
Charles P. Kokes				M.D. Assistant				10/4/87											
EXAMINER'S NAME (TYPE OR PRINT)																			
Charles P. Kokes, M.D.																			
ADDRESS																			
111 Penn St., Balto., Md. 21201																			
23a BURIAL, CREMATION, REMOVAL (SPECIFY)				23b DATE		23c NAME OF CEMETERY OR CREMATORY				23d LOCATION CITY OR TOWN COUNTY STATE									
Burial				Oct. 7, 1987		Oakland Cemetery				Waldorf, Charles, Md									
24 FUNERAL DIRECTOR NAME								25a DATE REC'D BY REGISTRAR				25b REGISTRAR'S SIGNATURE							
P.O. Box 156								OCT 06 1987				Julia Landon							
Huntt F.H. Waldorf, Maryland 20601																			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07-84
25M

BP

DHMH - 17
(VR A15 ME (5))

005520 001-291

GREEN MOUTON & CO

WELF. MINTFELD



005520 001-291

070067 OCT 29 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ARCHIE W. ROBINSON			2a DATE OF DEATH MONTH DAY YEAR 10-25-87		2b HOUR I :45AM	
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR April 22, 1906		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
10 CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN WHICH COUNTRY, GIVE STREET ADDRESS) PRINCE GEORGE'S HOSPITAL CENTER		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD		
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Labor Editor			12b KIND OF BUSINESS OR INDUSTRY US News World Report			
13a STATE Maryland			13b COUNTY Montgomery		13c CITY OR TOWN Chevy Chase	
13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS / ZIP CODE 7209 Oakridge Avenue 20815			
14 FATHER'S NAME FIRST MIDDLE LAST Walter Clarence Robinson			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Mackie			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO - - -		16b SOCIAL SECURITY NO 363-07-6546		17 INFORMANT Helen R. Clark		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) <u>Alzheimer's Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>30 minutes</u> <u>3 years</u>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>0</u>						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22 I certify that (1) (this hospital) attended the deceased from <u>8/28</u> 19 <u>87</u> to <u>10/25</u> 19 <u>87</u> that (1) <u>last</u> saw the deceased alive on <u>8/24</u> 19 <u>87</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) <u>last</u> and (1) <u>last</u> did not view the body after death.						
22b SIGNATURE <u>Leonard P. Appel</u>				22c DATE SIGNED 10/25/87		
22e PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Leonard P. Appel, M. D.				22f ADDRESS A-6 3231 Superior Lane Bowie, Maryland 20715		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE OCT 26, 1987		23c NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria, Fairfax, Virginia		
23d LOCATION CITY OR TOWN COUNTY STATE Alexandria, Fairfax, Virginia		24 FUNERAL DIRECTOR NAME ADDRESS Beall Funeral Home 16000 Annapolis Road Bowie, MD 20715-3043				
25a DATE REC'D BY REGISTRAR OCT 28 1987				25b REGISTRAR'S SIGNATURE <u>John R. Randle</u>		

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

068717 OCT 15 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

30443

1 DECEASED NAME (TYPE OR PRINT) Elizabeth Mantana Rock			2a. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> 10/7 19 87			2b. HOUR MIN <input type="checkbox"/> SEC <input type="checkbox"/> 5:14 P.			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> Jul. 10, 1892		6 AGE (IN YEARS) (LAST BIRTHDAY) YEARS <input type="checkbox"/> MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> 95		7c. DATE PRONOUNCED DEAD MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> 10/7 19 87	
7a. BIRTHPLACE (IF FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's County			
10 CITY OR TOWN OF DEATH Brentwood		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3814 - 38th Street				12a. USUAL OCCUPATION (TYPE OF WORK) (IF NOT WORKING, GIVE TYPE OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS US Gov't Treasury Dept.	
13a. STATE Maryland			13b. COUNTY Prince George's		13c. CITY OR TOWN Brentwood		13d. STREET ADDRESS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 3814 - 38th Street 20722		
14 FATHER'S NAME FIRST <input type="checkbox"/> MIDDLE <input type="checkbox"/> LAST <input type="checkbox"/> James Will			15 MOTHER'S MAIDEN NAME FIRST <input type="checkbox"/> MIDDLE <input type="checkbox"/> LAST <input type="checkbox"/> Amanda Rohrach			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. 213-46-5756			17 INFORMANT ADDRESS Edna M. Hill (Sister) Brentwood, Md. 20722						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myocardial disease. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) None									
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? None				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH None			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <input type="checkbox"/> 19 <input type="checkbox"/>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) None		21f. LOCATION STREET <input type="checkbox"/> CITY OR TOWN <input type="checkbox"/> COUNTY <input type="checkbox"/> STATE <input type="checkbox"/>				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>John S. Rogers</i>			TITLE (SPECIFY) Deputy			MEDICAL EXAMINER 1919 Seminary Road Silver Spring, Montgomery County, MD			
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.			DATE SIGNED 10/8/87			DATE REC'D. BY REGISTRAR OCT 14 1987			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/09/87		23c. NAME OF CEMETERY OR CREMATORY Huff's Church Cemetery		23d. LOCATION CITY OR TOWN <input type="checkbox"/> COUNTY <input type="checkbox"/> STATE <input type="checkbox"/> Huff's Church Berk Maryland		
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A.						25a. DATE REC'D. BY REGISTRAR OCT 14 1987			
4739 Baltimore Avenue Hyattsville, Md. 20781						25b. REGISTRAR'S SIGNATURE <i>John S. Rogers</i>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, REPLY PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

07-84
25M

BP

DHMH: 17
(VR A15 ME (5))

066717 OCT 1987

Female white Wolf. 10, 1992 99
Elizabeth Hamilton
1007 807

Prince George's County

Mt. Rainier
Maryland Prince George's Mt. Rainier
3014 - 30th Street

3014 - 30th Street

acute myocardial infarction.



None
None

None

X

John A. Rorer, M.D.
Silver Spring, Montgomery County, MD
1015 Seminary Road
Dorsey
1007 807

OCT 14 1987

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE IN PRINT) FIRST MIDDLE LAST Mollie G. Romans			2a DATE OF DEATH MONTH DAY YEAR Oct. 17, 1987			2b HOUR 12:30 P.		
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR March 1, 1897		6 AGE (IN YEARS LAST BIRTHDAY) 90 YRS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD		
10 CITY OR TOWN OF DEATH Adelphi		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Presidential Woods Nurs. Home		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b KIND OF BUSINESS OR INDUSTRY US Coast Guard		
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD			13b COUNTY Montgomery		13c CITY OR TOWN Olney		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Michael -- Goldstein			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lena -- (Unknown)					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No ---		16b SOCIAL SECURITY NO. 497-09-4721		17 INFORMANT 5000 Cathedral Avenue, N.W. Vera R. Glaser, Washington, D.C. 20016				
18 CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PERFORATED DIVERTICULUM COLON</u> <u>22 AUGUST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>ARTERIOSCLEROTIC VASCULAR DISEASE</u>								
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART I OR PART 2)				
21d INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22 I certify that (1) <u>Walter E. Goozh</u> attended the deceased from <u>OCT 14</u> 19 <u>87</u> to <u>OCT 17</u> 19 <u>87</u> that (2) <u>W</u> last saw the deceased alive on <u>OCT 14</u> 19 <u>87</u> and that in (my) <u>W</u> opinion death occurred on the date and hour and from the causes stated above. (If <u>W</u> did not view the body after death)								
22b SIGNATURE <u>Walter E. Goozh</u>						22c DATE SIGNED <u>OCT 17, 1987</u>		
22d PHYSICIAN'S NAME (TYPE OR PRINT) Walter E. Goozh				22e ADDRESS 2309 Shorefield Rd., Wheaton, MD 20902				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10/21/87		23c NAME OF CEMETERY OR CREMATORY King David Mem. Gdns.		23d LOCATION Falls Church, VA		
24 FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. NAME ADDRESS 5130 Wisconsin Ave, NW, Washington, D.C. 20016				25a DATE REC'D. BY REGISTRAR OCT 28 1987		25b REGISTRAR'S SIGNATURE <u>Lisa Davidson-Randall</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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March 1, 1995

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100-101

(continued)

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43-07-554

U. S. DEPARTMENT OF AGRICULTURE

Wood #5 Test 23

Five

565101

...and the

068275 OCT 13 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT) Harry Wilson Rose Jr			DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> 10-6 1987			HOUR <input type="checkbox"/> 6:25			
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> Oct 7 1918	6. AGE (IN YEARS) (LAST BIRTHDAY) 68 YRS	IF UNDER 1 YR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	7c. DATE PRONOUNCED DEAD MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> 10-6 1987	7d. HOUR <input type="checkbox"/> 6:25		
7a. BIRTHPLACE (STATE OR TERRITORY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George			
10. CITY OR TOWN OF DEATH Temple Hills		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3018 Brinkley Road Apt 101			12a. USUAL OCCUPATION (TYPE OF WORK) (IF NOT WORKING, GIVE REASON) Driver		12b. KIND OF BUSINESS OR INDUSTRY Transporta.		
13a. STATE Maryland			13b. COUNTY Pr George		13c. CITY OR TOWN Temple Hills		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST Harry MIDDLE W LAST Rose, Sr.			15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE M LAST Barnes			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES AND OR UNKNOWN) Yes (IF YES, GIVE DATES) WWII			
16b. SOCIAL SECURITY NO. 579 07 8344			17. INFORMANT Ruth L Rose			ADDRESS Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardiac relaxation cardiac vascular disease DUE TO OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (c) _____ DUE TO OR AS A CONSEQUENCE OF (c) _____									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Diabetic mellitus, Chronic obstructive pulmonary disease									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE Augusto P. Rodriguez			TITLE (SPECIFY) Deputy			DATE SIGNED 10-7-87			
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.			ADDRESS 5009 Rayburn Ct, Temple Hills, MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9 Oct 1987		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Maryland		
24. FUNERAL DIRECTOR NAME Robert E Wilhelm			ADDRESS Suitland Maryland			25a. DATE REC'D. BY REGISTRAR OCT 09 1987		25b. REGISTRAR'S SIGNATURE Wilson-Rose	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 201-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07 B4
25M

BP

DHMH - 17
(VR A15 ME (5))

00022 Oct 1961

00022 Oct 1961

069321 OCT 22 87

Item 24, File G633, 11-12-87, dw
FOR
STATE
REGISTRAR
per funeral homeSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

30440

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Martha C. Ross			2a DATE OF DEATH MONTH DAY YEAR October 15, 1987		2b HOUR P M 12:30 P
3 SEX FEMALE	4 RACE WHITE	5 DATE OF BIRTH MONTH DAY YEAR Feb 28 1902		6 AGE (IN YEARS LAST BIRTHDAY) 85 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 24 HRS
7a BIRTHPLACE (STATE OR FOREIGN) New York	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE MD.		
10 CITY OR TOWN OF DEATH Clinton	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital		12a USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) Stenographer	12b KIND OF BUSINESS OR INDUSTRY US Gov't	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE Maryland		13c COUNTY Pr Geo	13d CITY OR TOWN Clinton	13e STREET ADDRESS 6601 Horseshoe Road	
14 FATHER'S NAME Leopold MIDDLE Bare		15 MOTHER'S MAIDEN NAME Carrie MIDDLE LAST			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) No		16b SOCIAL SECURITY NO. 578 58 0940		17 INFORMANT ADDRESS Dorothy Anderson 5600 Strawbridge Ter Sykesville Md	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Shock</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerosis of Coronary Arteries</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes Mellitus and Peripheral Vascular Disease</u>					
19a DATE OF OPERATION 10/16/87		19b CONDITION FOR WHICH OPERATION WAS PERFORMED Thrombosis (R) Femoral GRAFT		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NO WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (b) (this hospital) attended the deceased from 19 15 to 10/16 19 87 that (b) (we) lost saw the deceased alive on 10/16 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death.					
22b SIGNATURE Joseph P. Chruso MD		DEGREE		22c DATE SIGNED 10/16/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Joseph P. Chruso MD		22e ADDRESS 9131 PISCATAWAY RD CLINTON MD			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 19 Oct 1987		23c NAME OF CEMETERY OR CREMATORY Washington National	
				23d LOCATION CITY OR TOWN COUNTY STATE Suitland Maryland	
24 FUNERAL DIRECTOR NAME Robert E Wilhelm Funeral Home Suitland Maryland		25a DATE REC'D. BY REGISTRAR OCT 20 1987			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

000 331 OCT 31

Handwritten notes and signatures at the top of the page, including a signature that appears to read "John F. Kennedy".

Handwritten notes and signatures in the middle section of the page, including a signature that appears to read "John F. Kennedy".

000 331 OCT 31

068739 OCT 16 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked ok, item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. STATE REGISTRAR					REG. NO.					
1 DECEASED NAME (TYPE OR PRINT) GEORGEANN EILEEN RUSSELL					2a DATE OF DEATH MONTH DAY YEAR OCTOBER 11 1987 2b HOUR 2:30 PM					
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR Dec. 30, 1919		6 AGE (IN YEARS LAST BIRTHDAY) -68- YRS.		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Connecticut		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD				
10 CITY OR TOWN OF DEATH Camp Springs		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Malcolm Grow Medical Center				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Military - Ret.		12b KIND OF BUSINESS OR INDUSTRY U.S. Air Force		
13a STATE Maryland					13b COUNTY Prince George		13c CITY OR TOWN Ft. Washington		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST George W. Russell, Sr.					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eileen E. O'Meara					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1944-1971		17 INFORMANT ADDRESS George W. Russell, Jr. 260 Merline Rd. Vernon, Conn.						
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>METASTATIC ADENOCARCINOMA OF THE OVARY</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. _____										
MEDICAL CERTIFICATION										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE						
22a I certify that (I) (the hospital) attended the deceased from <u>8 OCTOBER</u> 19 <u>87</u> to <u>11 OCTOBER</u> 19 <u>87</u> that (I) <input checked="" type="checkbox"/> saw the deceased alive on <u>11 OCTOBER</u> 19 <u>87</u> and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did not view the body after death.										
22b SIGNATURE <u>Beverly F Wedda</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED 11 OCTOBER 87		
22d PHYSICIAN'S NAME (TYPE OR PRINT) BEVERLY F WEDDA				22e ADDRESS MALCOLM GROW USAF MED CEN AAFB, MD 20331-5300						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10/16/87		23c NAME OF CEMETERY OR CREMATORY Arlington National Cem.		23d LOCATION Arlington COUNTY Virginia				
24 FUNERAL DIRECTOR NAME George P. Kalas Funeral Home				ADDRESS 6160 Oxon Hill Rd. Oxon Hill, Md.		25a DATE REC'D BY REGISTRAR OCT 15 1987		25b REGISTRAR'S SIGNATURE <u>John D. ...</u>		

100-100-100

100-100-100

066995 OCT 20 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 30450

FOR
1- STATE
REGISTRAR

REG. NO.

DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

2a DATE OF DEATH MONTH DAY YEAR

2b HOUR

Madeline M. Russo

September 26 1987 11:48 AM

3 SEX

4 RACE

5. DATE OF BIRTH

6 AGE (IN YEARS LAST BIRTHDAY)

7 UNDER 1 YEAR 8 UNDER 2 HRS

Female

White

Jan. 7, 1911

76 YRS

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

7b CITIZEN OF WHAT COUNTRY?

8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Rhode Island

U. S. A.

Prince George's

MD

10 CITY OR TOWN OF DEATH

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

12b KIND OF BUSINESS OR INDUSTRY

Lanham

Doctor's Hospital of P.G. Co.

Nurses Aide

Hospitals

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

13b COUNTY

13c CITY OR TOWN

13d INSIDE CITY LIMITS?

13e STREET ADDRESS / ZIP CODE

Maryland

Pr. Geo's

Upper Marlboro

YES ☒ NO ☐

10224 Prince Place/ 20772

14. FATHER'S NAME

FIRST

MIDDLE

LAST

15. MOTHER'S MAIDEN NAME

FIRST

MIDDLE

LAST

Cesare

Macchioni

Filomena

Gatta

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)

No

16b SOCIAL SECURITY NO

17 INFORMANT

14609 Cambridge Drive
Upper Marlboro, Md. 20772

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☒YES ☐ NO ☐21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18B PART 2) (OR PART 2)

21d INJURY OCCURRED

21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)

21f LOCATION

CITY OR TOWN

COUNTY

STATE

22a I certify that (1) this hospital attended the deceased from 9/23 to 9/26 1987 that (b) we lost sight of the deceased after on 9/25 and that in my own opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death)

22b SIGNATURE

DEGREE

M.D. ATTENDING PHYSICIAN

MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c DATE SIGNED

22d PHYSICIAN'S NAME (TYPE OR PRINT)

22e ADDRESS

Lewis Dennis, M.D.

6201 Greenbelt Rd., Suite U-11
Greenbelt, Md. 20770

23a BURIAL, CREMATION, REMOVAL (SPECIFY)

23b DATE

23c NAME OF CEMETERY OR CREMATORY

23d LOCATION

COUNTY

STATE

Burial

10/1/87

St. Ann's Catholic Cem.

Cranston

Rhode Island

24 FUNERAL DIRECTOR

Richard A. Coleman
Funeral Home-Upper Marlboro,
Maryland 20772

25a DATE RECEIVED BY STATE DEPARTMENT OF HEALTH

06719 1987

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

000000 000000



000000 000000

068992 OCT 20 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with 6-72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

2. DECEASED NAME
(TYPE OR PRINT)

BLANCHE C RYON

3. DATE OF DEATH MONTH DAY YEAR

10 07 87 6:35 PM

3. SEX

Female

4. RACE

White

5. DATE OF BIRTH

October 8, 1898

6. AGE (IN YEARS LAST BIRTHDAY)

89 YRS

7a. BIRTHPLACE (STATE OR FOREIGN)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

PRINCE GEORGES MD

10. CITY OR TOWN OF DEATH

CLINTON

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

St. Marylands Hospital

12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)

Homemaker

12b. KIND OF BUSINESS OR INDUSTRY

Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Pr. Geo's

13c. CITY OR TOWN

Upper Marlboro

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

14503 Main St./20772

14. FATHER'S NAME

Richard

MIDDLE

T.

LAST

Coffren

15. MOTHER'S MAIDEN NAME

Agatha

MIDDLE

--

LAST

Wells

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)

No

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO

17. INFORMANT

10714 Meadowhill Rd., Silver
James E. Vogts-Spring, Md. 2090118. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Cardiorespiratory arrest.

DUE TO, OR AS A CONSEQUENCE OF

(b)

Myocardial infarction

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

Arteriosclerotic cardiovascular cond.

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

Hypertension, senile dementia

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 10/6/87 to 10/7/87 that I (well) last saw the deceased alive on 10/6/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

23c. DATE SIGNED

10/8/87

23d. PHYSICIAN'S NAME (TYPE OR PRINT)

A. GONSAVES

23e. ADDRESS

6 Post Office RD Waldorf MD 20601

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b. DATE

10/10/87

23c. NAME OF CEMETERY OR CREMATORY

Trinity Cemetery

23d. LOCATION
(CITY OR TOWN COUNTY STATE)

Upper Marlboro (Pr. Geo's) Md.

24. FUNERAL DIRECTOR

Richard A. Coleman
Funeral HomeUpper Marlboro,
Maryland 20772

25a. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

OCT 19 1987

BP

088820 50130A

068995 OCT 20 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- STATE REGISTRAR		2a DATE KNOWN OF DEATH		2b HOUR	
3 DECEASED NAME (TYPE OR PRINT)		3 DATE KNOWN OF DEATH		3 HOUR	
Roland Russell Ryan		10-3-87		M	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS)	IF UNDER 1 YR	IF UNDER 24 HRS
Male	White	Jan. 13, 1896	91 YRS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED	NEVER MARRIED	WIDOWED	DIVORCED
Maryland	U.S.A.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Clinton	Southview Nursing Home Hospital	Accountant		Beer Distributor Company	
13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET ADDRESS	
Md.	Pr. Geo's	Upper Marlboro	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	14503 Main St/20772	
14 FATHER'S NAME	15 MOTHER'S MAIDEN NAME	16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			
Richard Nelson	Effie -- Lowe	No --			
16b SOCIAL SECURITY NO.	17 INFORMANT	17a ADDRESS			
218-03-2407	James E. Vogts	10714 Meadowhill Rd., Silver Spring, Md. 20901			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I DEATH WAS CAUSED BY					
885 IMMEDIATE CAUSE					
Aspiration pneumonia with Septicemia					
DUE TO OR AS A CONSEQUENCE OF					
(b) Thoracic vertebral (T10) fracture					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I					
Enter pneumonia					
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH	21b TIME OF INJURY	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
	9-26-87	Tripped over the steps			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f LOCATION			
	Home	14503 Main Street, Upper Marlboro, Pr. Geo's			
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Augusto P. Rodriguez		Deputy		10-5-87	
EXAMINER'S NAME (TYPE OR PRINT)					
Augusto P. Rodriguez, M.D.					
ADDRESS					
5009 Rayburn Ct., Temple Hills, MD					
23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION		
Burial	10/7/87	Trinity Cemetery	Upper Marlboro (Pr. Geo's) Md.		
24 FUNERAL DIRECTOR					
Richard A. Coleman Upper Marlboro, Md. 20772					
25 DATE REC'D. BY REGISTRAR					
10-19-87					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

060000000000

Poland House, 1700

1700

1700



1700

1700

1700

1700

1700

1700

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST MIDDLE LAST
HELEN M SCHEIBERT

2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR
10 2 87 10.50pm

3 SEX

FEMALE

4 RACE

CAUCASIAN

5 DATE OF BIRTH

MONTH DAY YEAR
4 19 1923

6 AGE (IN YEARS LAST BIRTHDAY)

64

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

WEST VIRGINIA

7b. CITIZEN OF WHAT COUNTRY?

USA

8 MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

PRINCE GEORGES COUNTY MD

10 CITY OR TOWN OF DEATH

CLINTON MD

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

SOUTHERN MARYLAND HOSPITAL

12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)

OWNER

12b. KIND OF BUSINESS OR INDUSTRY

RESTAURANT

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MARYLAND

13b. COUNTY

PRINCE GEO

13c. CITY OR TOWN

ACCOKEEK

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE

14411 BERRY ROAD (20607)

14 FATHER'S NAME

JAMES

MIDDLE

GLOVER

LAST

MCKINLEY

15 MOTHER'S MAIDEN NAME

EMMA

MIDDLE

EVANS

LAST

EVANS

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)

NO

16b. SOCIAL SECURITY NO
(IF YES, GIVE WAR OR DATES)

236-14-8807

17 INFORMANT

CHARLES BARTON/996 DOGWOOD DR./GOLDEN, CO 80401

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Hepatic coma

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) UGI bleeding secondary to esophageal varices

DUE TO, OR AS A CONSEQUENCE OF

(c) Cirrhosis of liverAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (b)

Septicemia

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 9-19 1987 to 10-2- 1987 that (I) (we) lastsaw the deceased alive on 10-2- 1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

above; (I) (we) did (did not) view the body after death.

22b. SIGNATURE

C. K. BHATIA

DEGREE

MD

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED

10-3-87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

C. K. BHATIA MD

22e. ADDRESS

8926 Woodyard Rd, Clinton MD 2073523a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

BURIAL

23b. DATE

10/6/87

23c. NAME OF CEMETERY OR CREMATORY

FAIRFAX MEM PARK

23d. LOCATION
CITY OR TOWN

FAIRFAX

COUNTY

FAIRFAX VIRGINIA

STATE

24 FUNERAL DIRECTOR

DEMAINE FUNERAL HOMES, INC ALEXANDRIA, VA 22314

25a. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

OCT 07 1987

BP

0303-007-001

43

0303-007-001

0303-007-001

069852 OCT 27 87

30454

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

DECEASED NAME FIRST MIDDLE LAST
Dr. Robert Paul Schelble

2a DATE KNOWN OF DEATH ☒ ESTIMATED ☐ MONTH DAY YEAR HOUR
10/ 18/ 87

3 SEX **Male** 4 RACE **White** 5 DATE OF BIRTH MONTH DAY YEAR **Sept. 24, 1925** 6 AGE (IN YEARS) LAST BIRTHDAY **62 YRS.** 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) **Maryland** 7b CITIZEN OF WHAT COUNTRY? **U.S.A.** 8 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 9 BALTIMORE CITY OR COUNTY OF DEATH **Prince George's County, MD**

10 CITY OR TOWN OF DEATH **Cheverly** 11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) **Prince George's General Hospital** 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) **Chiropractor** 12b KIND OF BUSINESS OR INDUSTRY **Own Office**

13a STATE **Maryland** 13b COUNTY **P.G.** 13c CITY OR TOWN **Hyattsville** 13d INSIDE CITY LIMITS? YES ☒ NO ☐ 13e STREET ADDRESS **6300 Landover Road 20785**

14 FATHER'S NAME FIRST MIDDLE LAST **Charles F. Schelble** 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST **Hazel Twiggs**

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) **Yes-Army** **Korean** 16b SOCIAL SECURITY NO. **218-16-4521** 17 INFORMANT (Wife) **Mary Ann Schelble** ADDRESS **6300 Landover Road Hyattsville, Md. 20785**

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) **Ruptured Dissecting Aneurysm of Aorta**
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a

19a DATE OF OPERATION 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? 20 AUTOPSY? YES ☒ NO ☐

21a EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR **P.M. 19** 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK ☐ AT WORK 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f LOCATION STREET CITY OR TOWN COUNTY STATE

22a I certify that (check change of the remains described above) held on death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion

ACTUAL SIGNATURE **Dennis F. Smyth, M.D.** TITLE (SPECIFY) **Assistant Medical Examiner** DATE SIGNED **10/20/87**

EXAMINER'S NAME (TYPE OR PRINT) **Dennis F. Smyth, M.D.** ADDRESS **111 Penn St., Balto., Md. 21201**

23a BURIAL, CREMATION, REMOVAL (SPECIFY) **Burial** 23b DATE **10/22/87** 23c NAME OF CEMETERY OR CREMATORY **Fort Lincoln Cemetery** 23d LOCATION CITY OR TOWN COUNTY STATE **Brentwood P.G. Maryland**

FUNERAL DIRECTOR **Francis Gasch's Sons Funeral Home, P.A.** 4739 Baltimore Avenue Hyattsville, Md. 20781

25a DATE REC'D BY REGISTRAR **OCT 28 1987** 25b REGISTRAR'S SIGNATURE **[Signature]**

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM-PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

068901 OCT 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

30455

1 DECEASED NAME (TYPE OR PRINT) JOHN J SCHIAVONE Sr.			2a DATE OF DEATH MONTH DAY YEAR OCT 11 1987		2b HOUR 1539 PM
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR OCT 17 1913		6 AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b CITIZEN OF WHAT COUNTRY? United States	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD	
10 CITY OR TOWN OF DEATH TAKOMA PARK	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASH. ADVENTIST HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF LAST WORKING LIFE) Accountant	12b KIND OF BUSINESS OR INDUSTRY Government	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a STATE Maryland	13b COUNTY P.G.	13c CITY OR TOWN Beltsville	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 4409 Orange St. 20705	
14 FATHER'S NAME FIRST MIDDLE LAST Charles Schiavone			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Muccio		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b SOCIAL SECURITY NO. 126-03-6740	17 INFORMANT ADDRESS Ethel C. Schiavone same as #13e		
18 CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary Atherosclerosis, Hardened DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis generalized APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a Multiple Myelomas					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART I OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from JUNE 58 to 11 OCT 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.					
22b SIGNATURE Thomas P. Fogarty		DEGREE MD		22c DATE SIGNED 11 OCT 87	
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS			
23a BURIAL, CREMATION, REMOVAL Burial		23b DATE 10-15-1987	23c NAME OF CEMETERY OR CREMATORY George Washington Cem.		23d LOCATION STREET CITY OR TOWN COUNTY STATE Adelphi P.G. Maryland
24 FUNERAL DIRECTOR Donald V. Borgwardt		4400 Powder Mill Rd. Beltsville, Md. 20705		25a DATE REC'D. BY REGISTRAR OCT 16 1987	25b REGISTRAR'S SIGNATURE Julia Dawson-Rudolph

MEDICAL CERTIFICATION

29

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

000001 001 1987

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

FOR
1 - STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR	
George M. Scott					10 06 87					1:05P M	
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
MALE	Black		MONTH 04 DAY 06 YEAR 12		75 YRS		MONTHS DAYS		HOURS MIN		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
District Of Columbia		USA				PRINCE GEORGE'S MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
CHEVERLY		PRINCE GEORGE'S HOSPITAL CENTER						Clerk			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS			
Maryland		Calvert		Huntingtown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3820 Capital Hill Lane 20639			
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST				FIRST MIDDLE LAST							
George A. Scott				Minnie L. Mathews							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b SOCIAL SECURITY NO		17 INFORMANT ADDRESS					
no				577-07-5721		Susan Scott 3820 Capital Hill Lane					
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY											
IMMEDIATE CAUSE (a) Cancer Prostate											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
Obstructive Uropathy (Cancer), Electrolyte abnormalities											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
		HOUR A.M. MONTH DAY YEAR									
		P.M. 19									
21d INJURY OCCURRED		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION							
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET		CITY OR TOWN		COUNTY		STATE	
22a I certify that (I) (this hospital) attended the deceased from 9/14 19 87 to 10/6 19 87 that (I) (we) last saw the deceased alive on 10/6 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE				DEGREE				22c DATE SIGNED			
[Signature]				M.D.							
22d PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS							
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION		CITY OR TOWN		COUNTY STATE	
Burial		Oct. 10, 87		Patuxent Chr. Cem.		Huntingtown		Calvert		Md	
24 FUNERAL DIRECTOR NAME				25a DATE REC'D BY REGISTRAR				25b REGISTRAR'S SIGNATURE			
Spencer E. Sewell				OCT 16 1987				[Signature]			
1451 Dares Beach Rd. Prince Frederick, Md											

BP

000100 001000

WESTCO

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1. FOR
STATE
REGISTRAR

1. DECEASED NAME

FIRST MIDDLE LAST

(OR PRINT)

GLADYS F. SCOTT

2a. DATE OF DEATH

MONTH DAY YEAR

10 29 87

2b. HOUR

4:55 PM

3 SEX

Female

4 RACE

Caucasian

5. DATE OF BIRTH

MONTH DAY YEAR
February 21, 1906

6 AGE (IN YEARS LAST BIRTHDAY)

81

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 2 YEARS

MONTHS DAYS

7a BIRTHPLACE

(STATE OR FOREIGN COUNTRY)

Penn.

7b CITIZEN OF WHAT COUNTRY?

U.S.A.

8 MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Prince Georges Co MD

10 CITY OR TOWN OF DEATH

Clinton

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
So. Maryland Hospital

12a USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker

12b KIND OF BUSINESS OR INDUSTRY

Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

Maryland

13b COUNTY

P. G.

13c CITY OR TOWN

District Hgts

13d INSIDE CITY LIMITS?

YES ☐ NO ☒

13e STREET ADDRESS / ZIP CODE

6204 District Height Parkway 20747

14 FATHER'S NAME

FIRST MIDDLE LAST
Berton Roy Shirley

15 MOTHER'S MAIDEN NAME

FIRST MIDDLE LAST
Minie Mae Kemmer

16a WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES NO OR UNKNOWN)

No

16b SOCIAL SECURITY NO

(IF YES, GIVE WAR OR DATES)

N/A

16c SOCIAL SECURITY NO

191-28-4661

17 INFORMANT

Russell Scott

ADDRESS 6806 Berkshire Dr

Camp Springs, Md 20748

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Pulmonary Embolism

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

b) Carcinoma thyroid gland & Ovary

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

YES ☒ NO ☐

20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)

21d INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e PLACE OF INJURY

(AT HOME STREET FACTORY OFFICE FARM ETC)

21f LOCATION

STREET CITY OR TOWN COUNTY STATE

22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last

saw the deceased when or showed (I) (we) that (I) (we) did not saw the body after death _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

22b SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☐MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c DATE SIGNED

22d PHYSICIAN'S NAME (TYPE OR PRINT)

EDWARD SHERER

22e ADDRESS

So. Maryland Med. Center

23a BURIAL, CREMATION, REMOVAL

(SPECIFY)

Burial

23b DATE

11/02/87

23c NAME OF CEMETERY OR CREMATORY

Ashbury Meth. Ch. Cem

23d LOCATION

Barstow

COUNTY

Calvert

STATE

Maryland

24 FUNERAL DIRECTOR Lee Funeral Home, Inc.

25a DATE REC'D BY REGISTRAR

NOV 04 1987

25b REGISTRAR'S SIGNATURE

Julia Davidson-Paulsen

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove completed pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

71021 NOV-8-61

3

69426 OCT 23 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

30458

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Norman C. Schroth			2a DATE OF DEATH MONTH DAY YEAR Oct 5 1987		2b HOUR 6⁵⁰ P M		
3 SEX male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR Feb 26 1905		6 AGE (IN YEARS LAST BIRTHDAY) YRS 82	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD	
10 CITY OR TOWN OF DEATH Greenbelt		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greenbelt Nursing Center		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE District of Columbia		13b COUNTY Washington		13c CITY OR TOWN Washington		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET ADDRESS / ZIP CODE 666 Maryland Ave. 20002 N.E.		14 FATHER'S NAME FIRST MIDDLE LAST Anton T. Schroth		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie Conlon			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO (IF YES GIVE WAR OR DATES) 578-01-2135		17 INFORMANT (Wife) Sue E. Schroth.		ADDRESS Washington, D.C. 20002 662 Maryland Ave. N.E.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cerebral Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis Generalis							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Carcinoma of Prostate, Prostatectomy, Lymphoma							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		19c AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		19d IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21 OR PART 2)			
21a INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21c LOCATION (STREET) CITY OR TOWN COUNTY STATE			
22a I certify that (i) (this hospital) attended the deceased from 15 July 1987 to 5 Oct 1987 that (i) (we) last saw the deceased alive on 5 Oct 1987 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (i) (we) (did) (did not) view the body after death.							
22b SIGNATURE Thomas P. Fogarty, M.D.				DEGREE M.D.		22c DATE SIGNED 5 Oct 87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Thomas P. Fogarty, M.D.				22e ADDRESS 7676 New Hampshire Ave. Langley Park, M.D.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10-9-87		23c NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.	
24 FUNERAL DIRECTOR J. William Lee's Sons Company				25a DATE REC'D. BY REGISTRAR OCT 15 1987		25b REGISTRAR'S SIGNATURE [Signature]	
300 4th St. N.E. Washington, D.C. 20002							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been issued by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the funeral home. The funeral home should file this certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18, shows any injury or other traumatic event, the medical examiner must be notified at once.

070866 NOV-58

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HANNA Marie SEALOCK			2a DATE OF DEATH MONTH DAY YEAR 10-28-87		2b HOUR 8 PM	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Oct. 10, 1904		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		6 AGE (IN YEARS LAST BIRTHDAY) 83 YRS		
10 CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) So. Maryland Hospital		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES CO MD		
13a STATE Maryland		13b COUNTY P.G.		13c CITY OR TOWN Ft. Washington		
14 FATHER'S NAME FIRST MIDDLE LAST John Philpott		15 MOTHER'S MAIDEN NAME MIDDLE LAST Lillian Crown				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-18-5792		17 INFORMANT (Granddaughter) 10325 Old Fort Road Charlene B. Bernsen Ft. Washington, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac pulmonary arrest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Stroke, Reizures, Pneumonia (c) Septic, Coma, COPD						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (a)						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART II)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from 10-12-87 to 10-28-87 that (I) (we) last saw the deceased alive on 10-28-87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b SIGNATURE L. H. ASAN		22c DEGREE MD		22e DATE SIGNED 10-29-87		
22d PHYSICIAN'S NAME (TYPE OR PRINT) ABULHASAN U ANSARI		22e ADDRESS 8926 Woodland Rd #101 Clinton Md 20735				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 11/02/87		23c NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		
23d LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland		24 FUNERAL DIRECTOR Francis Gasch's Sons Funreal Home, P.A. 4739 Baltimore Avenue Hyattsville, Maryland 20781				
25a DATE AND BY REGISTRAR		25b REGISTRAR'S SIGNATURE John Davidson-Randall				

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified of once.

BP

Mr. J. Edgar Hoover
Washington, D.C.

Dear Mr. Hoover:

I am writing to you regarding the matter of the

investigation of the activities of the

Communist Party, U.S.A.

and the activities of the

Communist Party, U.S.A.

and the activities of the

Communist Party, U.S.A.

and the activities of the

Communist Party, U.S.A.

and the activities of the

Communist Party, U.S.A.

and the activities of the

Communist Party, U.S.A.

and the activities of the

Communist Party, U.S.A.

and the activities of the

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

30400

070380

1- STATE REGISTRAR		2- DECEASED NAME (TYPE OR PRINT)		3- FIRST		4- MIDDLE		5- LAST		6a DATE KNOWN OF DEATH		6b MONTH		6c DAY		6d YEAR		6e HOUR	
		James						Seals		10-27		19		87					
7a SEX		7b RACE		8 DATE OF BIRTH		9 AGE (IN YEARS)		10 IF UNDER 1 YR.		11 IF UNDER 24 HRS.		12a DATE PRONOUNCED DEAD		12b MONTH		12c DAY		12d YEAR	
Male		White		12-8-15		71 YRS.						10-27		19		87		1127	
13a BIRTHPLACE (STATE OR FOREIGN COUNTRY)				13b CITIZEN OF WHAT COUNTRY?				14 MARRIED				15 NEVER MARRIED				16 BALTIMORE CITY OR COUNTY OF DEATH			
S. Carolina				U.S.A.				WIDOWED				DIVORCED				Prince Georges			
17 CITY OR TOWN OF DEATH				18 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				19 USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				20 KIND OF BUSINESS OR INDUSTRY							
Lanham				Doctors Hospital Of lanham				Vice-Principal				H/S							
21 USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				22 STATE				23 COUNTY				24 CITY OR TOWN				25 STREET ADDRESS			
Maryland				Pr. Geo.				College Pk.				6100 Westchester Pk. Dr.				20740			
26 FATHER'S NAME				27 MOTHER'S MAIDEN NAME				28 ADDRESS											
Unk.				Unk.				Therese D. Seals same as 13e											
29 WAS DECEASED EVER IN U.S. ARMED FORCES?				30 SOCIAL SECURITY NO.				31 INFORMANT											
Yes				WWII-Korea				042-32-1723											
32 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																			
PART I DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a) <u>Diabetic arteriosclerotic cardiovascular disease</u>																			
DUE TO, OR AS A CONSEQUENCE OF																			
DUE TO, OR AS A CONSEQUENCE OF																			
DUE TO, OR AS A CONSEQUENCE OF																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																			
33a DATE OF OPERATION				33b CONDITION FOR WHICH OPERATION WAS PERFORMED?															
34a EXTERNAL CAUSE WAS				34b TIME OF INJURY				34c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				P.M. 19															
35a INJURY OCCURRED				35b PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				35c LOCATION											
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>								CITY OR TOWN COUNTY STATE											
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>																			
36 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
37 ACTUAL SIGNATURE				38 TITLE (SPECIFY)				39 MEDICAL EXAMINER				40 DATE SIGNED							
Augusto P. Rodriguez				Deputy								10-27-87							
41 EXAMINER'S NAME (TYPE OR PRINT)				42 ADDRESS				43											
Augusto P. Rodriguez, M.D.				5009 Rayburn Ct, Temple Hills, MD															
44a BURIAL CREMATION, REMOVAL (SPECIFY)				44b DATE				44c NAME OF CEMETERY OR CREMATORY				44d LOCATION							
Burial				10/30/87				Arlington Nat'l Cem.				Arlington, Virginia							
45 FUNERAL DIRECTOR				46 DATE REC'D BY REGISTRAR				47 REGISTRAR'S SIGNATURE											
Rendon/Hale Lanham Fun'l Home				OCT 30 1987				Julia Gordon-Rudolph											
48 NAME				49 ADDRESS				50											
9013 Annapolis Rd. lanham, Md. 20706																			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

195-104 0-86070

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1. STATE
REGISTRARDECEASED NAME
(TYPE OR PRINT)FIRST
MabelMIDDLE
AleneLAST
SETTLE2a. DATE OF DEATH MONTH DAY YEAR
October 4, 19872b. HOUR
5:17 P^M

3 SEX

FEMALE

4 RACE

BLACK

5 DATE OF BIRTH

MONTH DAY YEAR
Sept. 7, 19156 AGE (IN YEARS LAST BIRTHDAY)
72 YRS7 UNDER 1 YEAR
MONTHS YEARS8 UNDER 1 YEAR
MONTHS YEARS7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Mississippi7b CITIZEN OF WHAT COUNTRY?
USA8 MARRIED ☐ NEVER MARRIED ☒
WIDOWED ☐ DIVORCED ☐9 BALTIMORE CITY OR COUNTY OF DEATH
Prince George's

MD

10 CITY OR TOWN OF DEATH
Lanham11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
A.M.I. Doctors' Hospital12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired12b KIND OF BUSINESS OR INDUSTRY
U. S. Government

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE
D.C.

13b COUNTY

13c CITY OR TOWN
Washington13d INSIDE CITY LIMITS?
YES ☒ NO ☐13e STREET ADDRESS / ZIP CODE
409 E Street, S.E.14 FATHER'S NAME
FIRST MIDDLE LAST
Will Settle15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Birdia Richardson16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No16b SOCIAL SECURITY NO.
579-05-081017 INFORMANT ADDRESS
Mrs. Mildred Bradford/1230 45th Pl. S E18 CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c)
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

YES ☐ NO ☒20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES ☐ NO ☐21a ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18b PART 1 OR PART 2)

21d INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM, ETC.)21f LOCATION
STREET CITY OR TOWN COUNTY STATE

22a I certify that (b) (this hospital) attended the deceased from 10/4, 1987, to 10/4, 1987, that (b) (we) last saw the deceased alive on 10/4, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death.

22b SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c DATE SIGNED

22d PHYSICIAN'S NAME (TYPE OR PRINT)

22e ADDRESS

23a BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation23b DATE
10-5-8723c NAME OF CEMETERY OR CREMATORY
Metropolitan Crematory23d LOCATION
CITY OR TOWN COUNTY STATE
Alexandria, Virginia

24 FUNERAL DIRECTOR

Washington, D.C.

John T. Rhines Company Funeral Home, 3015 12th St

25a DATE REC'D BY REGISTRAR

25b REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

001-100 488580

001-100 488580

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME FIRST MIDDLE LAST Eleanor Baker SHELTON			2a. DATE OF DEATH MONTH DAY YEAR October 26, 1987		2b. HOUR 6:55P M
3 SEX Female	4 RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Aug, 28, 1915	6 AGE (IN YEARS LAST BIRTHDAY) 72 YRS		IF UNDER 1 YEAR MONTH DAY HOUR MIN
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD		
10 CITY OR TOWN OF DEATH Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) waitress		12b KIND OF BUSINESS OR INDUSTRY restaurant

13a STATE Maryland			13b COUNTY Pr. George's	13c CITY OR TOWN Clinton	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> XX	13e STREET ADDRESS / ZIP CODE 6004 Arbroath Dr. 20735
-----------------------	--	--	----------------------------	-----------------------------	---	--

14 FATHER'S NAME FIRST MIDDLE LAST William T. Baker			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida VanBramer		
---	--	--	---	--	--

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) n/a	17 INFORMANT nephew Robert P. Baker Huntsville, Ala. 35803
---	--	--

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Kidney shut down</i>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
---	---

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last	(b) <i>Scars</i>
	(c) <i>Crippling Rheumatoid arthritis treated with cortisone</i>

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a DATE OF OPERATION 7/28/87	19b CONDITION FOR WHICH OPERATION WAS PERFORMED 13 leading abdominal wheel puncturing to the pancreas	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
----------------------------------	--	---	--

21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 2, OR PART 2)
---	---	--

21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE
---	---	--

22a I certify that (I) (this hospital) attended the deceased from <i>9/22/87</i> 19 to <i>10/26/87</i> 19 that (I) (we) last saw the deceased alive on <i>10/26/87</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did / did not view the body after death

23a SIGNATURE <i>Elie Sayan M.D.</i>	DEGREE	23c DATE SIGNED 10/27/87
---	--------	-----------------------------

23b PHYSICIAN'S NAME (TYPE OR PRINT) ELIE SAYAN	23e ADDRESS 5803 LANDOVER RD. CHEVERLY, MD.
--	--

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b DATE Oct. 28, 1987	23c NAME OF CEMETERY OR CREMATORY Lee Crematory	23d LOCATION CITY OR TOWN COUNTY STATE Clinton, Pr. George's MD
--	---------------------------	--	---

24 FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.	25a DATE REC'D. BY REGISTRAR OCT 28 1987	25b REGISTRAR'S SIGNATURE
---	---	---------------------------

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

150523 OCT 28 01

068772 OCT 16 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST MIDDLE LAST
Willie N. Shepherd

2a. DATE KNOWN OF DEATH ☒ MONTH ☐ DAY ☐ YEAR ☐ HOUR
ESTI MATED ☐ 10-12-87 M

3 SEX

4 RACE

5 DATE OF BIRTH

6 AGE (IN YEARS)

7 IF UNDER 1 YR

8 IF UNDER 24 HRS

2c. DATE PRONOUNCED DEAD

7d. HOUR

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

7b. CITIZEN OF WHAT COUNTRY?

8 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

10. CITY OR TOWN OF DEATH

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Md.

13b. COUNTY

P.G.

13c. CITY OR TOWN

Deanwood Park

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

4607 Zion St.

20743

14. FATHER'S NAME

FIRST MIDDLE LAST
*Lawrence**Shepherd*

15. MOTHER'S MAIDEN NAME

FIRST MIDDLE LAST
*Mary**Adair*

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.

577-32-7659

17. INFORMANT

ADDRESS

Nancy P. Wimes-Same as # 13 above

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

7 *912*

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

*Cardio-pulmonary arrest**Pulmonary carcinoma with metastatic deposits*

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

Arteriosclerotic cardiovascular disease

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK ☐ AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE

Augusto P. Rodriguez

M.D.

TITLE (SPECIFY)
Deputy

MEDICAL EXAMINER

DATE SIGNED

10-12-87

EXAMINER'S NAME (TYPE OR PRINT)

Augusto P. Rodriguez, M.D.

ADDRESS

5009 Rayburn Ct, Temple Hills, MD

23. BURIAL, CREMATION, REMOVAL

23b. DATE

10/17/87

23c. NAME OF CEMETERY OR CREMATORY

HARMONY MEM. PK.

23d. LOCATION

2 AND OVER P.G. MD

COUNTY

P.G.

STATE

MD

24. FUNERAL DIRECTOR

NAME

ADDRESS

H. S. WASHINGTON & SONS 4925 BURROUGH

25a. DATE REC'D. BY REGISTRAR

OCT 15 1987

25b. REGISTRAR'S SIGNATURE

James H. ...

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT, OR REMOVAL RECORD. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07-84
25M

BP

DHMH - 17
(VR A15 ME (5))

08072 OCT 16 67

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068569 OCT 14 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		7a DATE OF DEATH MONTH DAY YEAR		2b HOUR MIN	
RUBY B. Shockley				10/2/87		9 ³⁰ M	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY) YRS	
Female		Black		Aug. 16, 1925		62	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
North Carolina		USA				Prince Georges County MD	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
CLINTON		SOUTHERN MD. HOSPITAL CENTER		Retired-School		System	
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Washington, D.C.						13e STREET ADDRESS / ZIP CODE	
						1804 Branch Avenue, S.E.	
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Henry Broadway, Sr.		Cora Mae Parker					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS			
no		577 38 6450		Sears Shockley-husband-1804 Branch			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of the Lung</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 2b, PART 2 OR PART 3)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22 I certify that (I) (this hospital) attended the deceased from <u>9/27</u> 19 <u>87</u> to <u>10/3</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body of the deceased.							
22b SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED	
William Kaufman						Oct 5, 1987	
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS					
William Kaufman		Southern Maryland Hospitla					
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE	
Burial		Oct. 7, 1987		Cedar Hill Cemetery		Suitland, Maryland	
24 FUNERAL DIRECTOR NAME		24b DATE REC'D BY REGISTRAR		24c REGISTRAR'S SIGNATURE			
Stewart		OCT 09 1987		Julia Davidson-Randall			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

068203 OCT 14 85

ON ORDER
DOWD

John T. Brown

070399 NOV

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified of this.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Allen H. Sierer			2a DATE OF DEATH MONTH DAY YEAR 10 27 87		2b HOUR 6:50 p.m.
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR Sept. 7 1899		6 AGE (IN YEARS LAST BIRTHDAY) 88	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD	
10 CITY OR TOWN OF DEATH Forestville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Regency Nursing Home		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist - Ret.		12b KIND OF BUSINESS OR INDUSTRY Fed. Gov't.
13a STATE Maryland		13b COUNTY Prince George	13c CITY OR TOWN Temple Hills	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Frank C. Sierer		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie V. Horner		13e STREET ADDRESS / ZIP CODE 5100 Ludlow Drive 20748	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO. 577-50-7348		17 INFORMANT ADDRESS Kathleen Harris 4705 Henderson Rd. Temple Hills, Maryland	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Ca of Prostate & widespread mets. 1 yr.</u> DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) <u>Severe Anemia</u>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 2 OR PART 3)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (1) (this hospital) attended the deceased from <u>April 19 84</u> to <u>Oct 27 87</u> that I (we) lost saw the deceased alive on <u>10/27/87</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If yes) (which) (and) (when) (where) the body after death					
22b SIGNATURE <u>Kevin Minchin M.D.</u>		DEGREE		22c DATE SIGNED 10/28/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Kelvin Minchin M.D.		22e ADDRESS 6188 Oxon Hill Rd. Oxon Hill, Md.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10/31/87	23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. Maryland
24 FUNERAL DIRECTOR NAME G.P. Kalas F.H.		ADDRESS 6160 Oxon Hill Rd. Oxon Hill, Md.		25a DATE REC'D. BY REGISTRAR OCT 30 1987	25b REGISTRAR'S SIGNATURE <u>John J. Anderson</u>

BP

070309 NOV-58

Dear Sir,
I am writing to you
to inform you that
the project is
underway.

Very truly yours,
[Signature]

OCT 30 1958

068520 OCT 14 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

30400

1. DECEASED NAME (TYPE OR PRINT) <i>Jennie</i>			FIRST MIDDLE LAST <i>Silvestri</i>			2a. DATE KNOWN OF DEATH ESTI. MATED <input checked="" type="checkbox"/> 10-7-87			7b. HOUR M		
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>08/21/00</i>		6. AGE (IN YEARS) (LAST BIRTHDAY) <i>87</i> YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Arlington Mass.</i>				7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges</i> MD	
10. CITY OR TOWN OF DEATH <i>Clinton</i>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Southern Maryland Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE <i>Maryland</i>				13b. COUNTY <i>Prince Georges Dist</i>		13c. CITY OR TOWN <i>Hghts</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Joseph Longo</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Angelina Giarle</i>				13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>NO</i>				16b. SOCIAL SECURITY NO. <i>021-03-7860</i>				17. INFORMANT ADDRESS <i>Natalie Scimonelli same as #13</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterio Sclerotic cerebral vascular disease</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Arterio Sclerotic, Cerebral transient ischemic attacks</i>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>				TITLE (SPECIFY) <i>Deputy</i>				DATE SIGNED <i>10-8-87</i>			
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez, M.D.</i>				ADDRESS <i>5009 Rayburn Ct, Temple Hills, MD</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>10/10/87</i>				23c. NAME OF CEMETERY OR CREMATORY <i>St James Cemetery</i>			
23d. LOCATION CITY OR TOWN <i>Whitman Plymouth Mass.</i>				COUNTY <i>Plymouth</i>				STATE <i>Mass.</i>			
24. FUNERAL DIRECTOR NAME <i>Robert E. Wilhelm Funeral Home</i>								25a. DATE REC'D. BY REGISTRAR <i>OCT 13 1987</i>			
4308 Suitland Road, Suitland Maryland								25b. REGISTRAR'S SIGNATURE <i>Julia S. ...</i>			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07-84
25M

BP

DHMH 17
(VR A15 ME (1))

068220 OCT 14 01

RECEIVED
OCT 14 1901



OCT 13 1901

068160 OCT

FOR
STATE REGISTRAR
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BETTY P. Simmons			2a. DATE OF DEATH MONTH DAY YEAR 10 01 87		2b. HOUR 10:15A	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR March 4, 1943		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 44		
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Security Officer		12b. KIND OF BUSINESS OR INDUSTRY Security				
13a. STATE Maryland			13b. COUNTY P. G.		13c. CITY OR TOWN Upper Marlboro	
14. FATHER'S NAME FIRST MIDDLE LAST Doctor L. Simmons			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine R. Young			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) N/A		17. INFORMANT ADDRESS Karen P. Simmons 1311 Iverson St. #203 Oxon Hill Md 20745		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Intra cerebral Hemorrhage DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Hypertensive Crisis DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from October 1 19 87 to October 1 19 87 that (I) (we) last saw the deceased alive on October 1 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Stuart J. Goodman, MD		DEGREE MD		22c. DATE SIGNED Oct 2, 1987		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stuart J. Goodman, MD		22e. ADDRESS 7501 Sorells Rd. Clinton, MD 20735				
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 10/06/87		23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		
23d. LOCATION Clinton Prince George's Md.						
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.				25a. DATE REC'D. BY REGISTRAR OCT - 8 1987		
ADDRESS 6638 Old Alexander Ferry Rd Clinton, Md 20735				25b. REGISTRAR'S SIGNATURE Julia...		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRINCE ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed - the 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. There shall be no charge for this permit. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury as other than a natural event, the medical examiner will be notified at once.

 DHMH - 16 60M 7-84
 (VRA 15, 4) 6638

NO 01 1052

BATT

2. Summary

1. The first part of the report describes the general situation of the country and the progress of the war. It mentions the number of troops and the equipment of the army. It also mentions the progress of the war and the results of the battles. The second part of the report describes the situation of the country and the progress of the war. It mentions the number of troops and the equipment of the army. It also mentions the progress of the war and the results of the battles.

3. The third part of the report describes the situation of the country and the progress of the war. It mentions the number of troops and the equipment of the army. It also mentions the progress of the war and the results of the battles. The fourth part of the report describes the situation of the country and the progress of the war. It mentions the number of troops and the equipment of the army. It also mentions the progress of the war and the results of the battles.

4. The fourth part of the report describes the situation of the country and the progress of the war. It mentions the number of troops and the equipment of the army. It also mentions the progress of the war and the results of the battles. The fifth part of the report describes the situation of the country and the progress of the war. It mentions the number of troops and the equipment of the army. It also mentions the progress of the war and the results of the battles.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRARDECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

James

(N.M.I.)

SINCLAIR

2a DATE OF DEATH

MONTH

DAY

YEAR

2b HOUR

P
M

October

16

1987

5:30 P
M

3 SEX

Male

4 RACE

White

5 DATE OF BIRTH

March 18, 1913

6 AGE (IN YEARS LAST BIRTHDAY)

74

IF UNDER 1 YEAR

IF UNDER 2 YEARS

IF UNDER 3 YEARS

IF UNDER 4 YEARS

IF UNDER 5 YEARS

IF UNDER 6 YEARS

IF UNDER 7 YEARS

IF UNDER 8 YEARS

7a BIRTHPLACE

Ireland

7b CITIZEN OF WHAT COUNTRY?

U.S.A.

8

MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Prince George's

MD

10 CITY OR TOWN OF DEATH

Riverdale

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

Leland Memorial Hospital

12a USUAL OCCUPATION

Operating Engineer Navy Dept.

12b KIND OF BUSINESS OR INDUSTRY

U.S. Govt.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

Maryland

13b COUNTY

P.G.

13c CITY OR TOWN

Riverdale

13d INSIDE CITY LIMITS?

YES ☒ NO ☐

13e STREET ADDRESS & ZIP CODE

6005 Norman Avenue 20737

14 FATHER'S NAME

Robert

MIDDLE

LAST

Sinclair

15 MOTHER'S MAIDEN NAME

Lilly

MIDDLE

LAST

Freeman

16a WAS DECEASED EVER IN U.S. ARMED FORCES?

No

16b SOCIAL SECURITY NO.

577-09-5905

17 INFORMANT

(Wife)

6005 Norman Avenue

Roberta L. Sinclair Riverdale, Md. 20737

18 CAUSE OF DEATH Enter only one cause per line for a, b, and c

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Carcinoma of right lung

APPROXIMATE INTERVAL

BETWEEN ONSET AND DEATH

10 months

DUE TO, OR AS A CONSEQUENCE OF

(b) Carcinoma of hypopharynx

Unknown

Conditions, if any, which
gave rise to immediate
cause (c) stating the
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

YES ☐ NO ☒20b IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c HOW INJURY OCCURRED

ENTER NATURE OF INJURY IN REMARKS PART 2

21d INJURY OCCURRED

21e PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM, ETC.)

21f LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a I certify that (I) (this hospital) attended the deceased from 9 March 19 64 to 16 October 19 87 that (I) (we) last

saw the deceased alive on 16 October 19 87 and that in my (our) opinion death occurred on the date and hour and from the causes stated

22b SIGNATURE

DEGREE

ATTENDING
PHYSICIANMEDICAL
DIRECTOR ☒STAFF
PHYSICIAN ☐

22c DATE SIGNED

16 Oct. 1987

22d PHYSICIAN'S NAME (TYPE OR PRINT)

Carl J. Houmann, M. D.

22e ADDRESS

4404 Queensbury Rd., Riverdale, MD 20737

23a BURIAL, CREMATION, REMOVAL
(SPECIFY)

Cremation

23b DATE

10/20/87

23c NAME OF CEMETERY OR CREMATORY

Metropolitan Crematory Alexandria

Virginia

23d LOCATION

CITY OR TOWN

COUNTY

STATE

Francis G. Asch's Sons Funeral Home, P.A.

4739 Baltimore Avenue Hyattsville, Md. 20781

25a DATE REC'D. BY REGISTRAR

25b REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the local director, page 3 should be detached for use as the burial-transit permit. Then please remove the death certificate from the file and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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RECEIVED



RECEIVED

070390 NOV 12 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) George A. Six		2a DATE OF DEATH MONTH DAY YEAR 10-29-87		2b HOUR 6:41 AM
3 SEX Male	4 RACE Caucasian	5 DATE OF BIRTH MONTH DAY YEAR February 10, 1921		6 AGE (IN YEARS LAST BIRTHDAY) 66 YRS
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's Co. MD
10 CITY OR TOWN OF DEATH Clinton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Maryland Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance	
13a STATE Maryland		13b COUNTY Prince George	13c CITY OR TOWN Temple Hills	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST William A. Six		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Victoria Rose		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17 INFORMANT 2999 Brinkley Rd., Apt. 102 Temple Hills, Md.
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Lung Cancer DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Superior Vena Cava Syndrome DUE TO, OR AS A CONSEQUENCE OF: (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 19 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b)				
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (1) (this hospital) attended the deceased from March 1986 to 10/29 1987 that (1) saw last saw the deceased alive on 10/29 1987, and that in my (my) opinion death occurred on the date and hour and from the causes stated above, (1) (did not) view the body after death.				
22b SIGNATURE George P. Kalas				22c DATE SIGNED 10-29-87
22d PHYSICIAN'S NAME (TYPE OR PRINT) HARRY Z. KATZ		22e ADDRESS 8926 Woodlands Rd Clinton MD		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 10/31/87	23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. Maryland	
24 FUNERAL DIRECTOR NAME George P. Kalas Funeral Home		25a DATE REC'D BY REGISTRAR 6160 Oxon Hill Rd. Oxon Hill, Md.		25b REGISTRAR'S SIGNATURE DCT 30 1987 Julia Swisher-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "a", item 18 shows only injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- STATE		2a DATE KNOWN OF DEATH		2b HOUR	
REGISTRAR		DATE ESTIMATED		DAY YEAR	
3- DECEASED NAME (TYPE OR PRINT)		4- DATE OF DEATH		5- TIME OF DEATH	
FIRST MIDDLE LAST		MONTH DAY YEAR		HOURS MIN	
Claudio William Smith		9/27 1987		7:45 A.M.	
6- SEX	7- RACE	8- DATE OF BIRTH	9- AGE (IN YEARS)	10- IF UNDER 1 YR	11- IF UNDER 24 HRS
Male	White	MONTH DAY YEAR	LAST BIRTHDAY YRS	MONTHS DAYS	HOURS MIN
12- BIRTHPLACE (STATE OR FOREIGN COUNTRY)		13- CITIZEN OF WHAT COUNTRY?		14- MARRIED	
North Carolina		United States		NEVER MARRIED	
15- CITY OR TOWN OF DEATH		16- NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		17- USUAL OCCUPATION (TYPE OF WORK)	
Bowie		12016 Towanda Lane		School Board	
18- USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		19- CITY OR TOWN		20- STREET ADDRESS	
Maryland Prince George's		Bowie		2016 Towanda Lane	
21- FATHER'S NAME		22- MOTHER'S MAIDEN NAME		23- INFORMANT	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		ADDRESS	
Will Smith		Matilda Pickman		705 Moloy Dr. Waldorf, MD 20601	
24- WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		25- SOCIAL SECURITY NO.		26- WILLIAM L. SMITH, SR.	
yes		246-09-3450			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I DEATH WAS CAUSED BY					
IMMEDIATE CAUSE (a) <u>Acute myocardial disease</u>					
DUE TO, OR AS A CONSEQUENCE OF					
(b) <u>chronic myocardial disease.</u>					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I					
None					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY?	
None				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
		P.M. 19		None	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)		21f LOCATION (CITY OR TOWN COUNTY STATE)	
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		9/28/87	
John S. Rogers, M.D.		1919 Seminary Road Silver Spring, Montgomery County, MD			
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY	
Burial		Sept. 30, 1987		Ft. Lincoln Cemetery	
24 FUNERAL DIRECTOR NAME		25a DATE REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Beall Funeral Home		16000 Annapolis Road Bowie, Maryland 20715		SEP 30 1987 Julia Davidson-Randall	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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John B. Rogers, M.D.

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WALL STREET JOURNAL

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- DECEASED NAME (TYPE OR PRINT) ROBERT EUGENE SPENCE		2a DATE KNOWN OF DEATH MONTH DAY YEAR 10-10-87		2b HOUR M 15
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR 2-31-21	6 AGE (IN YEARS) LAST BIRTHDAY 66 YRS	IF UNDER 1 YR MONTHS DAYS 0 0
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		9b CITIZEN OF WHAT COUNTRY? U.S.A.		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD
10 CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Prince Georges General Hospital		12a USUAL OCCUPATION (TYPE OF WORK) Chief Bld. Engineer Press Bldg
13a STATE Maryland		13b COUNTY Prince Geo.	13c CITY OR TOWN Cheverly	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST Charles Spence		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith Sutton		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW-2	17 INFORMANT ADDRESS Betty Spence, Same as Line #13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF Ischemic cardiac disease Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I				
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE Augusto P. Rodriguez MD		TITLE (SPECIFY) Deputy		DATE SIGNED 10-10-87
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.		ADDRESS 5009 Rayburn Ct, Temple Hills, MD		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE Oct. 14, 87	23c NAME OF CEMETERY OR CREMATORY Md. National Cemetery	23d LOCATION CITY OR TOWN COUNTY STATE Laurel, P.G., Maryland	
JURISDICTION NAME FRANCIS GASCH'S SONS FUNERAL HOME, P.A.		ADDRESS 4739 Baltimore Ave., Hyattsville, Maryland		
DATE RECD. BY REGISTRAR OCT 14 1987		REGISTRAR'S SIGNATURE Julia Gordon-Rodell		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF A DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 1001. PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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RECEIVED OCT 10 1968

4 x 1

Robert

10-31-68

10-30-68

10-30-68

Chas. E. ...

August 1, 1968

10-30-68

OCT 14 1968

70556 NOV-387

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT)			2a DATE KNOWN OF DEATH ESTIMATED			2b DATE KNOWN OF DEATH ESTIMATED			2c DATE PRONOUNCED DEAD			2d DATE KNOWN OF DEATH ESTIMATED		
Carole Dent Springer			10/ 17/ 87			10/ 17/ 87			10/ 17/ 87			10/ 17/ 87		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE	IF UNDER 1 YR	IF UNDER 24 HRS	7a BIRTHPLACE			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED		
Female	Black	Jul. 7, 1917	70 RS			Georgia			USA			WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a USUAL OCCUPATION			12b KIND OF BUSINESS OR INDUSTRY			9 BALTIMORE CITY OR COUNTY OF DEATH		
Cheverly			Prince George's General Hospital			Child Care						Prince George's County, MD		
13a STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?			13e STREET ADDRESS		
District of Columbia			Washington			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			1311 Delaware Avenue, S.W.			Apt. 532 S		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			16a WAS DECEASED EVER IN U.S. ARMED FORCES?			16b SOCIAL SECURITY NO.			17 INFORMANT ADDRESS		
Charles Dent			Elizabeth Hankerson			no			264 18 1585			Alonzo Bailey-son-577 Broadway, Westbury, New York		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I DEATH WAS CAUSED BY														
IMMEDIATE CAUSE (a)														
DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.														
(b)														
DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I														
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY?					
									YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
			9:07 AM 10/ 15/ 87			driver of auto/auto collision								
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)			21f LOCATION								
			roadway			Pennsylvania & Silver Hill Rd., Pr. Geo., Md.								
22a I certify that I took charge of the remains described above, held on														
Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE			DATE SIGNED						MEDICAL EXAMINER					
Dennis F. Smyth, M.D.			10/20/87						111 Penn St., Balto., Md. 21201					
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION					
Burial			Oct. 22, 1987			Arlington National Cemetery, Arlington, Va								
24 FUNERAL DIRECTOR			25a DATE REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE								
Stewart Funeral Home-4001 Benning Road,			NOV 02 1987			Lisa Twicken-Randall								

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FORMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. This permit, along with this certificate, must be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as 1B, the only authorized funeral home, the medical examiner must be notified of the death.

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG NO 7 3047			
1 DECEASED NAME (TYPE OR PRINT) Thomas Carl Stanton				2a DATE OF DEATH MONTH DAY YEAR 10/12/79				2b HOUR 1:45 PM			
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR July 14, 1929		6 AGE (IN YEARS LAST BIRTHDAY) 58 YRS		IF UNDER 1 YEAR MONTH DAY		IF UNDER 1 YEAR MONTH DAY	
7a BIRTHPLACE (COUNTRY) Washington DC		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD					
10 CITY OR TOWN OF DEATH ADELPHI		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Presidential Wood N. Center				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Route Manager		12b KIND OF BUSINESS OR INDUSTRY Newspaper			
13a STATE Maryland				13b COUNTY Prince Geo.		13c CITY OR TOWN Seat Pleasant		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 610 Cabin Ranch Dr., 20743	
14 FATHER'S NAME FIRST MIDDLE LAST Joseph F. Stanton				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude Noll							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b SOCIAL SECURITY NO 579 38 3927		17 INEORMANT 1632 Arundel Rd., Edgewater, Joseph Stanton, Maryland 21037					
18 CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Cardio pulmonary Arrest								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10/12/79			
DUE TO OR AS A CONSEQUENCE OF b) Metastatic lung ca 6 mths to hip								14yr			
DUE TO OR AS A CONSEQUENCE OF c) ACDVD								14yr			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 10PD											
19a DATE OF OPERATION None				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that I, this hospital, attended the deceased from 10/12/79 to 10/12/79 that I saw the deceased alive on 10/10/79 and that in my opinion death occurred on the date and hour and from the causes stated above. (If you did not view the body after death, so state.)											
27b SIGNATURE G B Patrick III MD				DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		27c DATE SIGNED 10/12/79	
27d PHYSICIAN'S NAME (TYPE OR PRINT)				27e ADDRESS 4221 Lakeside Ave Silver Spring, MD 20900							
23a BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial				23b DATE Oct. 16, 1987		23c NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Washington D.C.			
24a FUNERAL DIRECTOR FRANCIS GASCH'S SONS FUNERAL HOME, P.A. 4739 Baltimore Ave., Hyattsville, Maryland						25a DATE REC'D. BY REGISTRAR OCT 19 1987		25b REGISTRAR'S SIGNATURE Julia Fenderson-Randall			

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3041

REG NO

FOR
1- STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Andrew

Crawford

Steele

7a DATE KNOWN OF DEATH ESTI MATED ☒ MONTH DAY YEAR 10/22 19 87 7b HOUR 8:16 A. M

3 SEX

4 RACE

5 DATE OF BIRTH

6 AGE (IN YEARS)

IF UNDER 1 YR

IF UNDER 24 HRS

7c DATE PRONOUNCED DEAD

8:16 A. M

Male

White

May 29, 1908

79 YRS.

MONTHS

DAYS

HOURS

MIN

10/22 19 87

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

7b CITIZEN OF WHAT COUNTRY?

8 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

SCOTTLAND

U.S.A.

Prince George's County MD

10 CITY OR TOWN OF DEATH

11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

College Park

7007 Fordham Court, #2

WELDER

12b KIND OF BUSINESS STEAMFITTERS UNION

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

13b COUNTY

13c CITY OR TOWN

13d INSIDE CITY LIMITS?

13e STREET ADDRESS

Maryland

Prince George's

College Park

YES ☒ NO ☐

7007 Fordham Court, #2

14 FATHER'S NAME

15 MOTHER'S MAIDEN NAME

ANDREW STEELE

MARY MARTIN

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)

16b SOCIAL SECURITY NO.

17 INFORMANT ADDRESS

NO

157-14-4517

MARY UPDIKE - daughter - s/a

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a) Acute myocardial disease

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

(b) chronic myocardial disease.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

None

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED?

20 AUTOPSY?

None

21a EXTERNAL CAUSE WAS

21b TIME OF INJURY

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

P.M. 19

None

21d INJURY OCCURRED

21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f LOCATION

WHILE ☐ NOT WHILE ☐ AT WORK ☐ AT WORK ☐

STREET

CITY OR TOWN

COUNTY

STATE

22a I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

TITLE (SPECIFY)

MEDICAL EXAMINER

DATE SIGNED 10/22/87

EXAMINER'S NAME (TYPE OR PRINT)

John S. Rogers, M.D.

ADDRESS 1919 Seminary Road Silver Spring, Montgomery County, MD

23a BURIAL, CREMATION, REMOVAL (SPECIFY)

23b DATE

23c NAME OF CEMETERY OR CREMATORY

23d LOCATION

COUNTY

STATE

Removal

10-22-87

24 FUNERAL DIRECTOR

NAME

25a DATE REC'D BY REGISTRAR

25b REGISTRAR'S SIGNATURE

State Anatomy Board

Balto., Md.

OCT 26 1987

Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

07-84
25M

BP
DHMH - 17
(VR A15 ME (5))

70 02 100 25 20 00

060615
0615 NOV -3 87FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH30476
REG NO

1 DECEASED NAME (TYPE OR PRINT) Charles Stewart		2a DATE KNOWN OF ESTI- DEATH MATED 10-26-87		2b HOUR 12	
3 SEX Male	4 RACE Black	5 DATE OF BIRTH MONTH DAY YEAR Aug 22, 1917	6 AGE (IN YEARS) LAST BIRTHDAY YRS. 70	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Croom, Md		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10 CITY OR TOWN OF DEATH District Hts		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2094 Addison Road Ht 1		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer self employed	
13a STATE Maryland		13b COUNTY Pr George		13c CITY OR TOWN District Hts	
14 FATHER'S NAME FIRST MIDDLE LAST Maggie Stewart		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maggie Stewart		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No	
16b SOCIAL SECURITY NO. 216-38-6231		17 INFORMANT Victoria S Stewart		ADDRESS 6461 Penna Ave Forestville Md	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE Diabetic arteriosclerosis the cardiovascular DUE TO, OR AS A CONSEQUENCE OF disease DUE TO, OR AS A CONSEQUENCE OF CONDITIONS, if any, which gave rise to immediate cause (a) stating the underlying cause lost PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE Augusto P. Rodriguez		TITLE (SPECIFY) Deputy		DATE SIGNED 10-27-87	
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.		ADDRESS 5009 Rayburn Ct, Temple Hills, MD			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE 29 Oct 1987		23c NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	
24 FUNERAL DIRECTOR NAME Robert E Wilhelm		25a REC'D BY REGISTRAR NOV 2 1987		25b REGISTRAR'S SIGNATURE Julia Davidson-Randall	
Funeral Home Suitland, Md.		23d LOCATION CITY OR TOWN COUNTY STATE Suitland PG Md			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM-PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07-84
25MBP
DHMH - 17
(VR A15 ME (1))

10-27-77
10-27-77

Mr. [illegible]
[illegible]

20% COLLOID LIME

20% COLLOID LIME



Applied [illegible]

30% [illegible] [illegible]

30% [illegible] [illegible]

NOV 28 1977

5
068819 OCT 1987STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

30417

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Elsie Stoneberger</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>October 9 1987</i>			2b. HOUR M <i>M</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>March 4 1904</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <i>83</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges County, MD</i>	
10. CITY OR TOWN OF DEATH <i>Lanham</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Magnolia Gardens Nursing Home</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Prince Georges</i>		13c. CITY OR TOWN <i>Lanham</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Henry Good</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Minnie Mayes</i>		13e. STREET ADDRESS / ZIP CODE <i>5422 Whitfield Chapel Rd. 20706</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>224-16-9370</i>		17. INFORMANT ADDRESS <i>Lanham, Maryland</i> <i>Manon Howsare/5422 Whitefield Chapel Rd.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>arteriosclerotic heart disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i> <i>2 years</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN REM OR PART 2 OR PART 3)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <i>JAN 1 19 87</i> to <i>OCT 9 19 87</i> that (1) (we) last saw the deceased alive on <i>10/7</i> 19 <i>87</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Nelson G. Goodman</i>				DEGREE <i>MD</i>		22c. DATE SIGNED <i>10/9/87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Nelson G. Goodman</i>				22e. ADDRESS <i>3231 Superior Lane Bowie, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>10/12/87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Adventist Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Stanley Page Virginia</i>	
24. FUNERAL DIRECTOR NAME <i>Bradley Fun. Hm., 187 E. Main St, Luray, Va</i>				25a. DATE RECD. BY REGISTRAR <i>OCT 15 1987</i>		25b. REGISTRAR'S SIGNATURE <i>William R. Jones</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP

000012 Oct 1941

RECEIVED

Handwritten notes and signatures in cursive script, including the word "received" and various illegible phrases.

188-11-100

068167 OCT-98

Item 13a, b, c, corrected by informant

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 30478

FOR STATE
2/9/89 Feb 11m G-648
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILFORD STOUT			2a DATE OF DEATH MONTH DAY YEAR 10 06 87		2b HOUR 12:00A M	
3 SEX MALE		4 RACE BLACK		5 DATE OF BIRTH MONTH DAY YEAR 09 09 44		
7a BIRTHPLACE (COUNTRY) Island British Virgin		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10 CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S HOSPITAL CENTER		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD		
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b KIND OF BUSINESS OR INDUSTRY				
13a STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Takoma		
14 FATHER'S NAME FIRST MIDDLE LAST Warren W. Stout		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Celectine Stout		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO. 100-42-5372		17 INFORMANT ADDRESS Myrtle Stout 6827 Red Top Rd #2 Takoma Pk. Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIORESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) AIDS WITH POSSIBLE SEPSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF						
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 4, OR PART 2)		
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from 10/6 19 87 to 10/6 19 87 that (I) (we) last saw the deceased alive on 10/6 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.						
22b SIGNATURE Nirmal Joshi		DEGREE		22c DATE SIGNED 10/7/87		
22d PHYSICIAN'S NAME (TYPE OR PRINT) NIRMAL JOSHI		22e ADDRESS P. G. Gen. Hospital				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10-13-87		23c NAME OF CEMETERY OR CREMATORY Church Cemetery		
23d LOCATION CITY OR TOWN COUNTY STATE Toatola British Island		24 FUNERAL DIRECTOR NAME Johnson & Jenkins 716 Kennedy St. N.W. Wash		25a DATE REC'D. BY REGISTRAR OCT - 8 1987		
25b REGISTRAR'S SIGNATURE Julia Dendron-Rudner						

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please attach carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, accident, traumatic event, the medical examiner must be notified at once.

BP _____

100-100 501000

100-100 501000

100-100 501000

100-100 501000

100-100 501000

100-100 501000

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

67 30477

1. FOR
STATE
REGISTRAR

REG. NO.

DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

2a DATE OF DEATH

MONTH

DAY

YEAR

2b HOUR

W. ILLIEN

STRONG

10 23 87

1³⁰ PM

3 SEX

FEMALE

4 RACE

BLACK

5 DATE OF BIRTH

NOV. 30 1962

6 AGE (IN YEARS LAST BIRTHDAY)

84

7 UNDER YEAR

IF UNDER 24 HRS

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

CHARLOTTE, N.C.

7b CITIZEN OF WHAT COUNTRY?

UNITED STATES

8 MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

PRINCE GEORGE'S

MD

10 CITY OR TOWN OF DEATH

FORESTVILLE

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

REGENCY NURSING HOME

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

RETIRED

12b KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

MARYLAND

13b COUNTY

P. G. CO.

13c CITY OR TOWN

LANDOVER

13d INSIDE CITY LIMITS?

YES ☐ NO ☒

13e STREET ADDRESS / ZIP CODE

1621 VILLAGE GREEN DR. 20784

14 FATHER'S NAME

ISSAC

MIDDLE

WAINWRIGHT

LAST

GREER

15 MOTHER'S MAIDEN NAME

FULA

MIDDLE

IRVING

LAST

IRVING

16a WAS DECEASED EVER IN U.S. ARMED FORCES?

NO

(IF YES, GIVE WAR OR DATES)

N/A

16b SOCIAL SECURITY NO

577-40-8720

17 INFORMANT

DELORES BAILEY (DAUGHTER) LANDOVER, MD.

ADDRESS 1621 VILLAGE GREEN DR.

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
PART 1 DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Acute Cardio-Pulmonary Arrest

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

2 mins.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

Heart Failure - Chronic Congestive

1 year

DUE TO, OR AS A CONSEQUENCE OF

Mitral Regurgitation

5 years.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

Debilitation, Cerebral Atrophy, Chronic Anemia

19a DATE OF OPERATION

None

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

None

20a AUTOPSY?

YES ☐ NO ☒

20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐

21a ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

21b TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

DNA

21d INJURY OCCURRED

WHILE ☐ NOT WHILE ☐

AT WORK ☐ AT WORK ☐

21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)

21f LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a I certify that (I) (this hospital) attended the deceased from Nov. 19, 86 to 10/22, 1987 that I (we) last

saw the deceased alive on 10/17, 1987 and that in my (our) opinion death occurred on the date and hour and from the causes stated

above, I (we) did not view the body after death.

22b SIGNATURE

Richard A. Farson

DEGREE

M.D.

ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c DATE SIGNED

10/23/87

22d PHYSICIAN'S NAME (TYPE OR PRINT)

Richard A. Farson, M.D.

22e ADDRESS

4401 Indianhead Hwy #360
Ft. Wash. Md. 20784

23a BURIAL, CREMATION, REMOVAL (SPECIFY)

BURIAL

23b DATE

10-29-87

23c NAME OF CEMETERY OR CREMATORY

ARLINGTON NATIONAL

23d LOCATION

CITY OR TOWN

ARLINGTON (ARL. CO.) VA.

COUNTY

STATE

24 FUNERAL DIRECTOR

NAME

HOFFMAN FUNERAL SERVICE

ADDRESS

3605 14th STREET N.W. WASH., D.C.

25a DATE REC'D BY REGISTRAR

OCT 27 1987

25b REGISTRAR'S SIGNATURE

John Gordon-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00000000000000000000

100% COTTON
MADE IN U.S.A.
100% COTTON
MADE IN U.S.A.

100% COTTON

20248 OCT 29 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 100.3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										30480 REG. NO.	
1- STATE REGISTRAR										2a DATE KNOWN OF DEATH	
2b DATE KNOWN OF DEATH										2c DATE PRONOUNCED DEAD	
3- DECEASED NAME FIRST MIDDLE LAST Willie Richard Studevent II										2d DATE KNOWN OF DEATH ESTIMATED 10-21-87	
4 SEX Male										2e DATE PRONOUNCED DEAD 10-21-87	
5 DATE OF BIRTH MONTH DAY YEAR 12-5-1969										2f DATE PRONOUNCED DEAD 10-21-87	
6 AGE (IN YEARS) LAST BIRTHDAY 17 YRS.										2g DATE PRONOUNCED DEAD 10-21-87	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.										2h DATE PRONOUNCED DEAD 10-21-87	
7b CITIZEN OF WHAT COUNTRY? U.S.A.										2i DATE PRONOUNCED DEAD 10-21-87	
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										2j DATE PRONOUNCED DEAD 10-21-87	
9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges										2k DATE PRONOUNCED DEAD 10-21-87	
10 CITY OR TOWN OF DEATH Camp Springs										2l DATE PRONOUNCED DEAD 10-21-87	
11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6711 Robinia Road										2m DATE PRONOUNCED DEAD 10-21-87	
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student										2n DATE PRONOUNCED DEAD 10-21-87	
12b KIND OF BUSINESS OR INDUSTRY School										2o DATE PRONOUNCED DEAD 10-21-87	
13a STATE Maryland										2p DATE PRONOUNCED DEAD 10-21-87	
13b COUNTY Prince Georges										2q DATE PRONOUNCED DEAD 10-21-87	
13c CITY OR TOWN Camp Springs										2r DATE PRONOUNCED DEAD 10-21-87	
13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										2s DATE PRONOUNCED DEAD 10-21-87	
13e STREET ADDRESS 6711 Robinia Road										2t DATE PRONOUNCED DEAD 10-21-87	
14 FATHER'S NAME FIRST MIDDLE LAST Willie Richard Studevent II										2u DATE PRONOUNCED DEAD 10-21-87	
15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elsie Marie Spaulding										2v DATE PRONOUNCED DEAD 10-21-87	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No										2w DATE PRONOUNCED DEAD 10-21-87	
16b SOCIAL SECURITY NO. 218-08-3668										2x DATE PRONOUNCED DEAD 10-21-87	
17 INFORMANT W. Richard Studevent II Same as #13 a-e.										2y DATE PRONOUNCED DEAD 10-21-87	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Shotgun wound of the head</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										2z DATE PRONOUNCED DEAD 10-21-87	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I										2aa DATE PRONOUNCED DEAD 10-21-87	
19a DATE OF OPERATION										2ab DATE PRONOUNCED DEAD 10-21-87	
19b CONDITION FOR WHICH OPERATION WAS PERFORMED?										2ac DATE PRONOUNCED DEAD 10-21-87	
20a DATE OF OPERATION										2ad DATE PRONOUNCED DEAD 10-21-87	
20b CONDITION FOR WHICH OPERATION WAS PERFORMED?										2ae DATE PRONOUNCED DEAD 10-21-87	
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 639 P.M. 10-21-87										2af DATE PRONOUNCED DEAD 10-21-87	
21b INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK										2ag DATE PRONOUNCED DEAD 10-21-87	
21c PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home										2ah DATE PRONOUNCED DEAD 10-21-87	
21d HOW INJURY OCCURRED (NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Self inflicted										2ai DATE PRONOUNCED DEAD 10-21-87	
21e LOCATION CITY OR TOWN COUNTY STATE Camp Springs, Prince Georges, Md										2aj DATE PRONOUNCED DEAD 10-21-87	
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										2ak DATE PRONOUNCED DEAD 10-21-87	
22b I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										2al DATE PRONOUNCED DEAD 10-21-87	
23a ACTUAL SIGNATURE Augusto P. Rodriguez										2am DATE PRONOUNCED DEAD 10-21-87	
23b EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.										2an DATE PRONOUNCED DEAD 10-21-87	
23c ADDRESS 5009 Rayburn Ct, Temple Hills, MD										2ao DATE PRONOUNCED DEAD 10-21-87	
23d BURIAL, CREMATION, REMOVAL (SPECIFY) Burial										2ap DATE PRONOUNCED DEAD 10-21-87	
23e DATE Oct 25, 1987										2aq DATE PRONOUNCED DEAD 10-21-87	
23f NAME OF CEMETERY OR CREMATORY Piney Grove A.M.E. Church										2ar DATE PRONOUNCED DEAD 10-21-87	
23g LOCATION CITY OR TOWN COUNTY STATE Mocksville Davie N.C.										2as DATE PRONOUNCED DEAD 10-21-87	
24 FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.										2at DATE PRONOUNCED DEAD 10-21-87	
24b ADDRESS 6633 Old Alexander Ferry Rd. Clinton, Md.										2au DATE PRONOUNCED DEAD 10-21-87	
25a DATE REC'D BY REGISTRAR OCT 28 1987										25b REGISTRAR'S SIGNATURE Borden R. Randle	

117-84
25M

BP
DHMH
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10-21-01

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10-21-01

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

30481
REG NO

FOR
1- STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Bret (N.M.I.) Suthard, Sr.			2a DATE KNOWN OF DEATH ESTI MATED 10/ 29/ 87		2b HOUR M
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR April 29, 1960	6 AGE IN YEARS LAST BIRTHDAY 27 YRS	IF UNDER 1 YR MONTHS DAYS HOURS MIN	IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD		10 CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hospital	
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Siding Mechanic		12b KIND OF BUSINESS OR INDUSTRY Construction		13a STATE Maryland	
13b COUNTY P.G.		13c CITY OR TOWN Riverdale		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET ADDRESS 5603 Rittenhouse Street		13f ZIP CODE 20737		14 FATHER'S NAME FIRST MIDDLE LAST Earle Franklin Suthard, Sr.	
15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia Ann Pilkerton		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b SOCIAL SECURITY NO. 213-82-9676	
17 INFORMANT ADDRESS 5603 Rittenhouse St.		18a NAME Diane Suthard (Wife)		18b ADDRESS Riverdale, Md. 20737	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY:
7 8147 IMMEDIATE CAUSE (a) Cranio-cerebral Trauma

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) DUE TO, OR AS A CONSEQUENCE OF

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR XX MONTH DAY YEAR 6:59 P.M. 10/ 28/ 87		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) pedestrian struck by auto
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.) roadway		21f LOCATION STREET CITY OR TOWN COUNTY STATE 5400 Blk. Kenilworth Ave., Riverdale, Pr. Geo. Md.

22a I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE *Margarita A. Korell* M.D. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 10/30/87
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn St., Balto., Md. 21201

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 11/03/87	23c NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	23d LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland
24 FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781		25a DATE REC'D BY REGISTRAR NOV 4 1987	25b REGISTRAR'S SIGNATURE <i>John D. Anderson-Randee</i>

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 checks any injury, or other traumatic event, the medical examiner may be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Oscar A. Swanson			2a DATE OF DEATH MONTH DAY YEAR 10 11 87			2b HOUR 8:00 PM			
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR December 2, 1900		6 AGE (IN YEARS LAST BIRTHDAY) 86		7 IF UNDER 1 YEAR MONTH DAY HOUR MIN YRS	
7a BIRTHPLACE (STATE OR FOREIGN) New York		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD			
10 CITY OR TOWN OF DEATH Clinton		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Md Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MAJOR OF WORKING LIFE) Self employed		12b KIND OF BUSINESS OR INDUSTRY Health Club	
13a STATE Maryland		13b COUNTY P. G.		13c CITY OR TOWN Ft. Washington		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 7502 Blanford Dr. 20744	
14 FATHER'S NAME FIRST MIDDLE LAST Anton Svensen			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hilda A. Peterson						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE YEAR OR DATES) No		16b SOCIAL SECURITY NO N/A		17 INFORMANT Clare Green		ADDRESS Same as 13 A-E			
18 CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF Stroke Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Stroke</u> DUE TO, OR AS A CONSEQUENCE OF Atherosclerosis (c) <u>Atherosclerosis</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>Chronic Bronchitis</u>									
19a DATE OF OPERATION /		19b CONDITION FOR WHICH OPERATION WAS PERFORMED /				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED /		21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>			
21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) /		21f LOCATION STREET /		21g CITY OR TOWN /		21h COUNTY /		21i STATE /	
22a I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>87</u> , to <u>11/10/87</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on above, (I) (we) did not see the body after death.									
22b SIGNATURE <u>Rene Grace</u>						DEGREE /		22c DATE SIGNED 12 Oct 87	
22d PHYSICIAN'S NAME Dr. <u>Rene Grace</u>						22e ADDRESS 9131 Piscataway Road #260			
23a BURIAL, CREMATION, REMOVAL (BY LAW) Cremation		23b DATE 10/12/87		23c NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d LOCATION (CITY OR TOWN) Clinton		23e COUNTY Prince George's	
24 FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.		24b ADDRESS 6633 Old Alexander Ferry Rd. Clinton Md 20735		25a DATE REC'D BY REGISTRAR OCT 14 1987		25b REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>			

BP

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1- FOR STATE REGISTRAR 10-30-87 per med exam

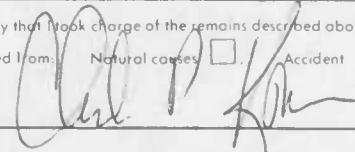

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 0 4 8 3
REG NO

069548 OCT

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING", IN PENCIL IN ITEM 18. FIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1 DECEASED NAME FIRST MIDDLE LAST 23 87 Curtis C. Tann Jr.		2a DATE KNOWN OF DEATH MONTH DAY YEAR 10-5-1987		2b HOUR M 6:40
3 SEX Male	4 RACE Black	5 DATE OF BIRTH MONTH DAY YEAR 8 3 65	6 AGE (IFY YEARS) (LAST BIRTHDAY) 22 YRS	7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.
7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County	
10 CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince Georges General Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Construction
12b KIND OF BUSINESS OR INDUSTRY Private		13a STATE Maryland		
13b COUNTY P. George's		13c CITY OR TOWN Palmer Park		
13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 7733 Bender Road/20785		
14 FATHER'S NAME FIRST MIDDLE LAST Curtis Carroll Tann, Sr.		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Billie A. Griffin		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b SOCIAL SECURITY NO. 218-92-2108		17 INFORMANT Billie A. Tann
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Narcotic intoxication DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a				
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 10-5 1987	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject took drugs	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.) HOUSE	21f LOCATION STREET CITY OR TOWN COUNTY STATE 731 Mentor Avenue Capital Heights, P.G., MD.	
22a I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion				
ACTUAL SIGNATURE 		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER		DATE SIGNED 10-6-87
EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D.		ADDRESS 111 Penn Street, Balto., MD 21201		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 10-10-87	23c NAME OF CEMETERY OR CREMATORY Harmony Memorial Pk	23d LOCATION CITY OR TOWN COUNTY STATE Landover P.G. Md.	
24 FUNERAL DIRECTOR NAME J.B. Jenkins	ADDRESS 7474 Landover Road Landover, Md. 20785	25a DATE REC'D. BY REGISTRAR OCT 22 1987	25b REGISTRAR'S SIGNATURE 	

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070484 NOV-28

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7-84
(VRA 15. 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) DANIEL C. TAYLOR				2a DATE OF DEATH MONTH DAY YEAR 10 22 87 HOUR 8:15 AM			
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR MAY 24, 1916		6 AGE (IN YEARS LAST BIRTHDAY) 71 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES CO. MD.	
10 CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES GEN. HOSPT.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RET. MAINTENANCE MAN	
13a STATE MD.		13b COUNTY P.G.C.		13c CITY OR TOWN LANDOVER HILLS		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST DANIEL C. TAYLOR				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EUGIE DIXON			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) WWII		17 INFORMANT MARY MALLET		ADDRESS SAME AS ITEM #13	
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ASPIRATION PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) ALZHEIMER'S DISEASE (ADVANCED) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS YEAR
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 8B PART 2 OR PART 21)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE			
22a I certify that (a) this hospital attended the deceased from 10/22 87 to 10/22 87 that (b) I saw the deceased and (c) I saw the body after death							
22b SIGNATURE Stuart Turkewitz		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		DATE SIGNED 10/22/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) STUART TURKEWITZ, M.D.				22e ADDRESS 7500 GREENWAY CTR. DR. #430 GREENBELT, MD. 20770			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b DATE 10-23-1987		23c NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE RIVERDALE, P.G.C. Md.	
24 FUNERAL DIRECTOR NAME W. W. CHAMBERS CO.				ADDRESS 20737 RIVERDALE, P.G.C. Md.		25a DATE REC'D BY REGISTRAR'S SIGNATURE OCT 30 1987 Julia Benson-Randall	

0101 84-101-581

PRIME C 10/15

DATE: 10/15/84

TO: [illegible]

FROM: [illegible]

SUBJECT: [illegible]

RE: [illegible]

10/15/84

10/15/84

10/15/84

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100-100 03005



068131 OCT 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, (21201) PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 10/07/87	23c NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	23d LOCATION (CITY OR TOWN, COUNTY, STATE) Brentwood P.C. Maryland
74 FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A.		25b DATE REC'D BY REGISTRAR OCT 8 1987	
4739 Baltimore Avenue Hyattsville, Md. 20781		25c REGISTRAR'S SIGNATURE <i>Julia Gordon-Randall</i>	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Head Injuries Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause last (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE TIME ELAPSED BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)		
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12:00 PM 10/ 3/ 87	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) driver of auto/fixed object collision
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) roadway	21f LOCATION (CITY OR TOWN, COUNTY, STATE) Kenilworth Ave., Greenbelt, Pr. Georges, Md.
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		
ACTUAL SIGNATURE <i>Charles P. Kokes</i> EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D.		TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 10/3/87
ADDRESS 111 Penn St., Balto., Md. 21201		

1- STATE REGISTRAR MD			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH			30480 REG. NO.		
2a DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Rodney Lee Taylor						2b DATE KNOWN OF DEATH ESTI MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 10/ 3/ 87		
3 SEX Male			4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Dec. 6, 1964		6 AGE (IN YEARS) (BIRTHDAY) MONTH DAY HOURS MIN 22	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10 CITY OR TOWN OF DEATH Cheverly			11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hospital			12a USUAL OCCUPATION (TYPE OF WORK) (INDUSTRY) Laborer		
13a STATE Maryland			13b COUNTY P.G.		13c CITY OR TOWN Riverdale		13d INSURE (CITY LIMITS?) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Claude E. Taylor, Sr.			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen J. Beverlin			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) No		
16b SOCIAL SECURITY NO 217-94-3608			17 INFORMANT ADDRESS 5303 Gallatin Street			18b BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD		
18c BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD			18d BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD			18e BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD		

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(VR A15 ME (5))

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070011 OCT 23 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove embargoes, pages 1 and 2, and 2 should be buried within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked by item 18 about any injury, or other traumatic event, the medical examiner must be notified at once.

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(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
FOR STATE REGISTRAR					REG. NO.				
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST THELMA DELORES TAYLOR					2a DATE OF DEATH MONTH DAY YEAR OCT 22 1987			2b HOUR 10:30p _M	
1 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR MARCH 7, 1911		6 AGE (IN YEARS LAST BIRTHDAY) 76 YRS		IF UNDER 1 YEAR MONTH DAY HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH P.G. MD			
10 CITY OR TOWN OF DEATH CAMP SPRINGS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANDREWS AIR FORCE BASE HOSP.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SELF EMP.		12b KIND OF BUSINESS OR INDUSTRY BEAUTICIAN	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE MD.					13c CITY OR TOWN ST. MARY'S LEXINGTON PARK		13d INSIDE CITY LIMITS? NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST WILLIE W. HURLEY					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ETHEL McGRADY				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			16b SOCIAL SECURITY NO. 579-03-0110		17 INFORMANT ADDRESS A, JAMES EMMETT TAYLOR, SAME AS 13E.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>EXSANGUINATION</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>UPPER GI BLEED UNKNOWN SOURCE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2: OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>30 SEP</u> 19 <u>87</u> to <u>22 OCT</u> 19 <u>87</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>22 OCT</u> 19 <u>87</u> , and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> did not view the body after death.									
22b SIGNATURE <u>JOHN T. COLUMBUS</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED 22 OCT 1987		
22d PHYSICIAN'S NAME (TYPE OR PRINT) JOHN T. COLUMBUS, CAPT, USAF MC				22e ADDRESS MG USAF MC, ANDREWS AFB, MD 20331-5300					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE 10-27-87		23c NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		23d LOCATION CITY OR TOWN COUNTY STATE ARLINGTON, ARLINGTON CO. VA.			
24 FUNERAL DIRECTOR NAME W. CLARKE MATTINGLEY, LEONARDTOWN, MD.				25a DATE REC'D. BY REGISTRAR OCT 27 1987		25b REGISTRAR'S SIGNATURE			

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

30486

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANTHONY J. THOMAS			2a DATE KNOWN OF DEATH MONTH DAY YEAR 10 28 19 87		2b HOUR M 2:42 A
3 SEX Male	4 RACE Black	5 DATE OF BIRTH MONTH DAY YEAR 9 30 61	6 AGE (IN YEARS) LAST BIRTHDAY 26 YRS.	7c DATE PRONOUNCED DEAD MONTH DAY YEAR 10 28 19 87	7d HOUR M 2:42 A
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9a CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hosp.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer	
13a STATE Maryland		13b COUNTY P. Georges	13c CITY OR TOWN Landover	13d STREET ADDRESS 6715 Eldridge Street	
14 FATHER'S NAME FIRST MIDDLE LAST Gilbert Edward Thomas			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gladys Victoria Thompson		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b SOCIAL SECURITY NO. 578-92-4293		17 INFORMANT ADDRESS 8407 Hamlin St #101 Gladys Thomas Glenarden, Md. 20706	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ Gunshot wound of thorax (handgun) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1:54 PM 10-28-19 87		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Shot by police.	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) building		21f LOCATION STREET CITY OR TOWN COUNTY STATE 3334 Brightseat Rd., Landover, Prince George's, MD	
22a I certify that I took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion					
ACTUAL SIGNATURE 		TITLE (SPECIFY) M.D. Deputy Chief		DATE SIGNED 10-28-87	
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.		ADDRESS 111 Penn St., Balto., MD 21201			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 11-3-87	23c NAME OF CEMETERY OR CREMATORY Harmony Memorial Pk. Landover		23d LOCATION CITY OR TOWN COUNTY STATE P.G., Md.
24 FUNERAL DIRECTOR NAME J.B. Jenkins		ADDRESS 7474 Landover Road Landover, Md. 20785		25a DATE REC'D BY REGISTRAR NOV 04 1987	
				25b REGISTRAR'S SIGNATURE 	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 57-1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO.

30489

1 DECEASED NAME (TYPE OR PRINT) Cosa R. Thomas			2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 10-12-87 MATED <input type="checkbox"/> MONTH DAY YEAR 10-12-87		2b HOUR M 1222 A PM
3 SEX Female	4 RACE Cauc.	5 DATE OF BIRTH MONTH DAY YEAR Aug. 6, 1891	6 AGE (IN YEARS) (LAST BIRTHDAY) YRS. 96	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c DATE PRONOUNCED DEAD MONTH DAY YEAR 10-12-87
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges		10 CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince Georges Hospital	
12a USUAL OCCUPATION (TYPE OF WORK) Homemaker		12b KIND OF BUSINESS OR INDUSTRY Home		13a USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland 13b COUNTY Prince Georges 13c CITY OR TOWN Capitol Hgts.	
13d INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS 613 Larchmont Ave. 20743			
14 FATHER'S NAME FIRST MIDDLE LAST Eason Montelle		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Jackson Clark			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No (IF YES, GIVE WAR OR DATES) N/A		16b SOCIAL SECURITY NO. 224 18 9379		17 INFORMANT ADDRESS Evelyn Zellars same as #13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Arthritis; dyspepsia					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Augusto P. Rodriguez		TITLE (SPECIFY) Deputy		DATE SIGNED 10-12-87	
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.		ADDRESS 5009 Rayburn Ct, Temple Hills, MD			
23a BURIAL, CREMATION, REMOVAL, DATE Oct. 15, 1987		23b NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23c LOCATION CITY OR TOWN STATE Alexandria, Virginia	
24 FUNERAL DIRECTOR NAME Ives-Pearson Funeral Homes		ADDRESS Arlington, Virginia		25a DATE REC'D. BY REGISTRAR OCT 19 1987	
				25b REGISTRAR'S SIGNATURE John Davidson-Randall	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. GIVE PAGE 1, 2, 3, 4, 5 TO THE FUNERAL DIRECTOR. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, 3, 4, 5 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. REMAINING PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

Joseph A. Thomas

2a. DATE KNOWN OF DEATH ESTIMATED ☒ MONTH DAY YEAR 10 11 1987

3 SEX

M

4 RACE

W

5 DATE OF BIRTH

MONTH DAY YEAR

10 29 1958

6 AGE (IN YEARS)

YRS

MONTHS

DAYS

HOURS

MIN.

IF UNDER 1 YR

IF UNDER 24 HRS

7c. DATE PRONOUNCED DEAD

MONTH DAY YEAR

10 11 1987

PM

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Colorado

7b. CITIZEN OF WHAT COUNTRY?

U.S.

8 MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Prince Georges

10 CITY OR TOWN OF DEATH

Laurel

11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Greater Laurel Beltsville Hwy. Rd. 1st. Surg. Dept. of Army

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS OR INDUSTRY

13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

STATE

COUNTY

13c. CITY OR TOWN

El Paso

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS

701 Montana

99999

14 FATHER'S NAME

FIRST

MIDDLE

LAST

Albert

Thomas

15 MOTHER'S MAIDEN NAME

FIRST

MIDDLE

LAST

Mary

R. Sierra

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)

16b. SOCIAL SECURITY NO.

17 INFORMANT

ADDRESS

Prince Frederick, MD

201 Helena Dr. 20178

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

DUETO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

(b)

DUETO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20 AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21d. INJURY OCCURRED

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion

ACTUAL SIGNATURE

TITLE (SPECIFY)

M.D.

MEDICAL EXAMINER

DATE SIGNED

10 11 1987

EXAMINER'S NAME (TYPE OR PRINT)

ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

24 FUNERAL DIRECTOR

NAME

ADDRESS

25a. DATE RECD. BY REGISTRAR

10 13 1987

Georgetown Univ. Med. Sch.

Washington, DC

1661 Good Hope Rd, SE

OCT 19 1987

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH 17
(VR A15 ME (1))

20 OCT 1950

REPT 10104 1155

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068405 OCT 14 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH30491
REG. NO.

1 DECEASED NAME (TYPE OR PRINT)			FIRST JASMINE			MIDDLE THOMPSON			LAST			2a DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> 10 9 1987			2b HOUR M 2:30		
3 SEX FEMALE		4 RACE JAMICAN		5 DATE OF BIRTH MONTH DAY YEAR 5 5 55		6 AGE (IN YEARS) BIRTHDAY MONTHS DAYS HOURS MIN 32 YRS		IF UNDER 1 YR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD MONTH DAY YEAR 10 9 1987			2d HOUR M 2:30		
7a BIRTHPLACE (STATE OR COUNTRY)				7b CITIZEN OF WHAT COUNTRY?				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD					
10 CITY OR TOWN OF DEATH Hyattsville				11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 780 Fairview Ave.								12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOTEL WORKER			12b KIND OF BUSINESS OR INDUSTRY HOTEL		
13a STATE MD				13b COUNTY PG		13c CITY OR TOWN HYATTSVILLE				13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 780 FAIRVIEW AVENUE					
14 FATHER'S NAME CLARENCE THOMPSON								15 MOTHER'S MAIDEN NAME JANE TORWERS									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b SOCIAL SECURITY NO. 579-02-2797				17 INFORMANT PAULINE THOMPSON COLLEGE, PARK, MD 5009 BERWYN DR.									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple gunshot wounds (unspecified weapon)</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under</u> <u>lying cause last</u> : (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a																	
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?								20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 10-9- 19 87				21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Subject shot.									
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.) home				21f LOCATION STREET CITY OR TOWN COUNTY STATE 780 Fairview Ave., Hyattsville, Prince George's MD									
22a I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE Mario F. Golle, Jr.				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER DATE SIGNED 10-10-87													
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS Mario F. Golle, Jr., M.D. 111 Penn St., Balto., MD 21201													
23a BURIAL, CREMATION, REMOVAL SPECIFY BURIAL				23b DATE 10-17-87				23c NAME OF CEMETERY OR CREMATORY GLENNWOOD				23d LOCATION CITY OR TOWN COUNTY STATE WASHINGTON, DC					
24 FUNERAL DIRECTOR NAME W.H. BACON FUNERAL				ADDRESS 3447 14th St				25a DATE REC'D. BY REGISTRAR OCT 13 1987				25b REGISTRAR'S SIGNATURE John Davidson-Pandey					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

(17-84
25M)

BP

DHMH - 17
(VR A15 ME (5))

1884 02 OCT 14 21

100% COTTON FIBER

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Handwritten notes and signatures at the top of the page, including a signature that appears to be "J. H. ...".

Handwritten notes in the middle section of the page, including a signature that appears to be "J. H. ...".

Handwritten notes and signatures at the bottom of the page, including a signature that appears to be "J. H. ...".

MEDICAL CERTIFICATION

DHMH 16 60M 7/84
(VRA 15, 4)

68771 OCT 16 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELMER M. TILGHMAN		2a DATE OF DEATH MONTH DAY YEAR 10 01 87		2b HOUR 37PM
3 SEX Male	4 RACE Black	5. DATE OF BIRTH MONTH DAY YEAR May 20, 1915		6 AGE (IN YEARS LAST BIRTHDAY) 72 YRS
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD
10 CITY OR TOWN OF DEATH CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES HOSPITAL CENTER		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Warehouseman	12b KIND OF BUSINESS OR INDUSTRY U.S. Gov't.
13a STATE Md.		13b COUNTY P.G.	13c CITY OR TOWN Cap. Hgts.	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST John Tilghman		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alberta Hawkins		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) WW II		17 INFORMANT ADDRESS Estelle Tilghman-Same as # 13 above
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <u>CEREBROVASCULAR ACCIDENT</u>				
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)		
21d INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)	21f LOCATION CITY OR TOWN COUNTY STATE		
22a I certify that (1) (this hospital) attended the deceased from <u>9-20</u> 19 <u>87</u> to <u>9-30</u> 19 <u>87</u> that (1) (we) last saw the deceased alive on <u>9-30</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did (did not) view the body after death)				
22b SIGNATURE <i>R. G. Bhojraj MD</i>		DEGREE M.D.		22c DATE SIGNED 10-2-87
22d PHYSICIAN'S NAME (TYPE OR PRINT) R.G. BHOJRAJ, M.D.		22e ADDRESS 704 GORMAN AVE T-1, LAUREL, MD 20707		
23a BURIAL CREMATION, REMOVAL (SPECIFY)	23b DATE 10/6/87	23c NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEM.	23d LOCATION CITY OR TOWN COUNTY STATE BETHESDA, P.G. MD.	
24 FUNERAL DIRECTOR NAME H.S. WASHINGTON & SONS		ADDRESS 4925 BURROUGHS AVE. N.		25a DATE REC'D BY REGISTRAR OCT 15 1987
		25b REGISTRAR'S SIGNATURE <i>Julia Davidson-Rodriguez</i>		

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked by item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove to Baltimore, Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

BP

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069602 OCT 23 87

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD, 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGE NO. 1, 2, 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORMS 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										30493 REG. NO.	
1- STATE REGISTRAR											
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Rita Turnbull										7a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 10/12 19 87	
2 SEX RACE Female White										7b HOUR 11:30	
3 DATE OF BIRTH MONTH DAY YEAR Aug. 23, 1905										7c DATE PRONOUNCED DEAD 10/12 19 87	
4 AGE (IN YEARS) (LAST BIRTHDAY) MONTH DAYS HOURS MIN 82 YRS										7d HOUR 11:30	
5 IF UNDER 1 YR IF UNDER 24 HRS MONTHS DAYS HOURS MIN										7e DATE PRONOUNCED DEAD 10/12 19 87	
6 BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA										7f BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD	
7a CITIZEN OF WHAT COUNTRY? USA										7g MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8 CITY OR TOWN OF DEATH Hyattsville										9 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 1902 Fox Street, #201	
10 USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE 13b COUNTY 13c CITY OR TOWN Maryland Prince George's Hyattsville										11 USUAL OCCUPATION (TYPE OF WORK) FOR MOST OF WORKING LIFE HOMEMAKER	
12 NAME OF FATHER'S NAME FIRST MIDDLE LAST FRANK KILLGALLON										13 STREET ADDRESS 1902 Fox Street, #201 20783	
14 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELLEN										15	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO										16b SOCIAL SECURITY NO. 212-74-9111	
17 INFORMANT ADDRESS DAVID TURNBULL/SON/SAME AS 13										18	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the liver. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) None											
19a DATE OF OPERATION None										19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19										21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>										21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.) None	
21f LOCATION (CITY OR TOWN) COUNTY STATE None											
22a I certify that I took charge of the remains described above, held on death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion	
ACTUAL SIGNATURE <i>John S. Rogers</i> M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER										DATE SIGNED 10/13/87	
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.										ADDRESS 1919 Seminary Road Silver Spring, Montgomery County, MD	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL										23b DATE OCT 15, 1987	
23c NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEM										23d LOCATION (CITY OR TOWN) COUNTY STATE ARLINGTON VIRGINIA	
24 FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR.										25a DATE REC'D. BY REGISTRAR OCT 22 1987	
25b REGISTRAR'S SIGNATURE <i>John S. Rogers</i>											
26 ADDRESS 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901											

07/84
25MBP
DHMH - 17
(VR A15 ME 15)

000000000000

May

June

July

August

Female White Aug. 23, 1902 35

Prince George's County

Hyattsville 1902 Fox Street, 4001

Maryland Prince George's Hyattsville 1902 Fox Street, 4001

Cardiogram of the liver.



None

None

None

X

X

Barney

1910 Cemetery Road

Silver Spring, Montgomery County, Md.

John E. Rogers, M.D.

10/13/07

070719 NOV

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. **IMPORTANT:** If item 21 is marked or item 18 shows any injury or other traumatic event, the death certificate must be notified at once.DHMH - 16 50M 4/83
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Alice M. Tyler</i>			2a DATE OF DEATH MONTH DAY YEAR <i>10 29 87</i>			2b HOUR A.M. P.M. <i>9.55 A.M.</i>			
3 SEX <i>Female</i>		4 RACE <i>Black</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>07 06 08</i>		6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <i>79</i>		7b HOURS MIN. <i>9.55</i>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>TENNESSEE</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges County MD</i>			
10 CITY OR TOWN OF DEATH <i>Nyattsouille</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Nyattsouille Manor</i>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>DEPT. OF DEFEN.</i>		12b KIND OF BUSINESS OR INDUSTRY <i>FED. GOV.</i>	
13a STATE <i>D.C.</i>		13b COUNTY <i>Prince George Washington</i>		13c CITY OR TOWN <i>Washington</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE <i>3801 Connecticut Avenue NW</i>	
14 FATHER'S NAME FIRST MIDDLE LAST <i>GEORGE MOORE</i>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>AMANDA (UNKNOWN)</i>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>NO</i>				16b SOCIAL SECURITY NO. <i>577-05-445</i>		17 INFORMANT <i>ROSEMARIE BROOKS-DAU. WASH., DC 20011</i>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cancer of Lung</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>7 months</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <i>Apr. 14 1987</i> to <i>Apr. 29 1987</i> that I (we) last saw the deceased alive on <i>10 29 87</i> 19 <i>87</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <i>Robert T. Dibble</i>						DEGREE <i>M.D.</i>		22c DATE SIGNED <i>10-29-87</i>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>ROBERT T. DIBBLE</i>						22e ADDRESS <i>1140 VARNUM ST., NE WASH., DC 20018</i>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>			23b DATE <i>11/3/87</i>		23c NAME OF CEMETERY OR CREMATORY <i>LINCOLN MEMORIAL</i>		23d LOCATION CITY OR TOWN COUNTY STATE <i>SUITLAND, (P.G.C.) MD.</i>		
24 FUNERAL DIRECTOR NAME ADDRESS <i>MORROW & WOODFORD, INC. 1622 11TH. ST. NW WASH., D. C. 20001</i>						25a DATE REC'D. BY REGISTRAR <i>NOV 3 1987</i>		25b SIGNATURE OF REGISTRAR <i>Julia Southern-Rudolph</i>	

MEDICAL CERTIFICATION

050712 OCT-40

1000

1000

NOV 2 1941

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 30497

1- FOR
STATE
REGISTRAR

REG. NO.

1- DECEASED NAME FIRST MIDDLE LAST George S. Van Hook			2a DATE OF DEATH MONTH DAY YEAR 10-19-87		2b HOUR A. M.
3 SEX Male	4 RACE Black	5 DATE OF BIRTH MONTH DAY YEAR 9 21 1915		6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 11 19	
7a BIRTHPLACE STATE OR FOREIGN COUNTRY W. VA.	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George MD	
10 CITY OR TOWN OF DEATH Landover	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Residence/1916 Oregon Ave		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Guard		12b KIND OF BUSINESS OR INDUSTRY Govt
13a STATE Md	13b COUNTY PG	13c CITY OR TOWN Landover	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 1916 Oregon Ave/20785	
14 FATHER'S NAME FIRST MIDDLE LAST Earnest Van Hook		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Freeland			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW11		16b SOCIAL SECURITY NO 233129707	17 INFORMANT ADDRESS Landover, Md Angelina C. Van Hook/1916 Oregon Ave		
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) Inoperable Cancer DUE TO, OR AS A CONSEQUENCE OF (c) Colon.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER!)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN REMARKS, PART 2 OR PART 3)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK WHILE <input type="checkbox"/> NOT AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from July 1985 to Present 19 that I (we) last saw the deceased alive on 10-1-1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE M. K. MOHAN		DEGREE M.D.		22c DATE SIGNED 10/21/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) M. K. MOHAN		22e ADDRESS			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10/23/87	23c NAME OF CEMETERY OR CREMATORY Harmony		23d LOCATION CITY OR TOWN COUNTY STATE Landover PG MD.
24 FUNERAL DIRECTOR NAME JB JENKINS/7474 LANDOVER RD		25a DATE REC'D. BY REGISTRAR OCT 22 1987		25b REGISTRAR'S SIGNATURE	

000000 000000

069844 OCT 27 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

30490

1 DECEASED NAME (TYPE OR PRINT) Florence Ella Van Orman			2a DATE OF DEATH MONTH 10 DAY 16 YEAR 87			2b HOUR 1105PM					
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH September DAY 20 YEAR 1904		6 AGE (IN YEARS LAST BIRTHDAY) 83		7 UNDER 1 YEAR MONTHS DAYS 			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD					
10 CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Manor Nursing Home				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY Own Home			
13a STATE Maryland			13b COUNTY Montgomery		13c CITY OR TOWN Silver Spring		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 423 East Indian Spring Drive 20901		
14 FATHER'S NAME FIRST William MIDDLE LAST O'Bryan			15 MOTHER'S MAIDEN NAME FIRST Ella MIDDLE LAST Curran			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b SOCIAL SECURITY NO 093-24-9473	
17 INFORMANT (Son) Ernest B. Van Orman			17 ADDRESS Califon, New Jersey			18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Scale Recurrent Stroke Right Cerebral DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) 				APPROXIMATE TIME BETWEEN ONSET AND DEATH 07830	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Remote Stroke with left hemiplegia Advanced Organized Brain Syndrome											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)			21f LOCATION STREET (CITY OR TOWN COUNTY STATE)					
22 I certify that (i) (this hospital) attended the deceased from Jan 19 85 to Oct 16 19 87 that (ii) (we) last saw the deceased alive on Oct 16 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (not) view the body after death.											
22a SIGNATURE Richard L. Whelton MD						DEGREE MD		22c DATE SIGNED 10-17-87			
22d PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD L. WHELTON						22e ADDRESS 4700 Benning House Rd College Park MD					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 10/21/87		23c NAME OF CEMETERY OR CREMATORY Brookside Cemetery			23d LOCATION (CITY OR TOWN COUNTY STATE) Shortsville Ontario New York			
24 FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A.						25a DATE REC'D. BY REGISTRAR OCT 26 1987		25b REGISTRAR'S SIGNATURE John P. ...			
4739 Baltimore Avenue Hyattsville, Md. 20781											

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

088044 OCT 27 1971

10 16 51 11 00 PM Von T. J. ...

[Faint, mostly illegible text on lined paper, possibly a letter or report. Some words like "Dear Sir" and "Sincerely" are faintly visible.]

069850 OCT 27 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

FOR
1- STATE
REGISTRAR

2a DECEASED NAME
(TYPE OR PRINT)

FIRST MIDDLE LAST
William Joseph Villeneuve

2b DATE KNOWN OF DEATH ☒ MONTH DAY YEAR 1987
ESTIMATED ☐ 10-18 1987

3 SEX
Male

4 RACE
White

5 DATE OF BIRTH
MONTH DAY YEAR
August 29, 1899

6 AGE (IN YEARS)
LAST BIRTHDAY
88

IF UNDER 1 YR
MONTHS DAYS

IF UNDER 24 HRS
HOURS MIN

7c DATE PRONOUNCED DEAD
MONTH DAY YEAR
10-18 1987

7d HOUR
M
3:03 P

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Canada

7b CITIZEN OF WHAT COUNTRY?
U.S.A.

8 MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH
Prince George's County

10 CITY OR TOWN OF DEATH
Lanham

11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Doctor's Hospital

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Carpenter

12b KIND OF BUSINESS OR INDUSTRY
Union Local

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE
Maryland

13b COUNTY
Anne Arundel

13c CITY OR TOWN
Severna Park

13d INSIDE CITY LIMITS?
YES ☒ NO ☐

13e STREET ADDRESS
833 Dwidging Road 21146

14 FATHER'S NAME
FIRST MIDDLE LAST
Joseph Villeneuve

15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ellen Rooney

16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No

16b SOCIAL SECURITY NO
(IF YES, GIVE WAR OR DATES)
579-03-6725

17 INFORMANT (Son) *4907 Somerset Road*
Noel F. Villeneuve Riverdale, Md. 20737

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY

IMMEDIATE CAUSE

Ischemic cardiovascular disease

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

(b) DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED?

20 AUTOPSY?

YES ☐ NO ☒

21a EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d INJURY OCCURRED WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)

21f LOCATION
STREET CITY OR TOWN COUNTY STATE

22a I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☐ Inquiry ☐ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Augusto P. Rodriguez

TITLE (SPECIFY)
Deputy

M.D.

MEDICAL EXAMINER

DATE SIGNED *10-19-87*

EXAMINER'S NAME (TYPE OR PRINT)

Augusto P. Rodriguez, M.D.

ADDRESS *5009 Rayburn Ct, Temple Hills, MD*

23a BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial

23b DATE
10/21/87

23c NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cem.

23d LOCATION
Silver Spring Montgomery Md.

24 FUNERAL DIRECTOR
Francis Gasch's Sons Funeral Home, P.A.
4739 Baltimore Avenue Hyattsville, Md. 20781

25a DATE REC'D BY REGISTRAR
OCT 26 1987

25b REGISTRAR'S SIGNATURE
John D. ...

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

B7-B4
25A

BP

DHMH 17
(VR A15 ME (5))

06970 OCT 27 01

William Joseph Williams

10-11-01

10-11-01



James Williams

10-11-01

10-11-01

10-11-01

10-11-01

10-11-01

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

FOR
1 - STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) LEONARD VINEBERG		2a DATE OF DEATH MONTH DAY YEAR 10 31 1987		2b HOUR 4:09 PM
3 SEX MALE	4 RACE WHITE	5 DATE OF BIRTH MONTH DAY YEAR 11 - 27 - 1897		6 AGE (IN YEARS (LAST BIRTHDAY)) 89 YRS
7a BIRTHPLACE (COUNTRY) ROY N. Y.	7b CITIZEN OF WHAT COUNTRY? U. S. A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD
10 CITY OR TOWN OF DEATH HYATTSVILLE	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOME CARE ROLL MANOR NURSING		12a USUAL OCCUPATION (TYPE OF WORK OR MAIN MODE OF WORKING LIFE) ENGRAVER	12b KIND OF BUSINESS OR INDUSTRY OWNER

13a USUAL RESIDENCE (IF NURSING HOME, GIVE STREET ADDRESS) MARYLAND PRINCE GEORGE'S		13b INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13c STREET ADDRESS / ZIP CODE 4922 LASALLE ROAD 20782
--	--	--	--

14 FATHER'S NAME FIRST MIDDLE LAST Archibald Vineberg	15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BETTE FRANK FURT
---	--

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 578-01-4604	17 INFORMANT ADDRESS SHIRLEY C. GREENBAUM, 2304 ROSS ROAD SILVER SPRING, MARYLAND
---	--	--

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH -
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u>		Year
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Oxygen Brain Syndrome</u>		
--	--	--

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
---	---	---

21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK	21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)	21f LOCATION CITY OR TOWN STREET COUNTY STATE
---	---	--

22a I certify that (1) (this hospital) attended the deceased from <u>10/31</u> 19 <u>87</u> to <u>10/31</u> 19 <u>87</u> that I (we) last saw the deceased alive on <u>10/31</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did not view the body after death	
---	--

22b SIGNATURE <u>Don H. Yablonsky</u>	DEGREE <u>MD</u>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED <u>10/31/87</u>
--	---------------------	--	------------------------------------

22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>Don H. Yablonsky, MD</u>	22e ADDRESS <u>10300 Greenbelt Rd Seabrook, Md. 20706</u>
---	--

23a BURIAL, CREMATION, REMOVAL <u>BURIAL</u>	23b DATE <u>11/3/1987</u>	23c NAME OF CEMETERY OR CREMATORY <u>WASHINGTON HEBREW MEMORIAL CONGREGATION</u>	23d LOCATION <u>WASHINGTON, D.C.</u>
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24 FUNERAL DIRECTOR <u>DONALD M. STEIN</u>	24b ADDRESS <u>HEBREW MEMORIAL FUNERAL HOME</u>	24c DATE OF DEATH <u>NOV 03 1987</u>	24d REGISTRAR'S SIGNATURE <u>[Signature]</u>
---	--	---	---

232 CARROLL STREET, N. W., WASHINGTON, D.C.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

171228 NOV-54

100% COTTON FIBER

Handwritten notes and markings, including a large 'X' and various illegible text.

069124 OC 20

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 is checked, the medical examiner must be notified at once.)

BP _____

DHMH 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) George L. Vonmach			2a DATE OF DEATH MONTH DAY YEAR 10-10-87			2b HOUR 11A M					
3 SEX MALE		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR 8-5-04		6 AGE (IN YEARS LAST BIRTHDAY) 83		7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MICHIGAN			
7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD			10 CITY OR TOWN OF DEATH HYATTSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL MANOR NURSING HOME		
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PRESIDENT			12b KIND OF BUSINESS OR INDUSTRY GEN. UNT.			13a STREET ADDRESS / ZIP CODE 2953 MOZART DRIVE 20904			13b COUNTY MONTGOMERY		
13c CITY OR TOWN SILVER SPRING			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS / ZIP CODE 2953 MOZART DRIVE 20904			13f STATE MARYLAND		
14 FATHER'S NAME FIRST MIDDLE LAST MAXIMILIAN E. VON MACH			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY ANN SINK			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 1951-1954		
16c SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 378-09-0987			17 INFORMANT ADDRESS ANN FISHER/DAUGHTER/SAME AS 13			18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebro Vascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last b) _____ DUE TO, OR AS A CONSEQUENCE OF c) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Severe generalized Vascular Disease</u>											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			21d INJURY OCCURRED AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>		
21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE			22a I certify that (1) (the hospital) attended the deceased from <u>MARCH 19 84</u> to <u>OCT 19 87</u> that I saw the deceased alive on above, and that in my opinion death occurred on the date and hour and from the causes stated above, and that (my) view the body after death.			22b SIGNATURE <u>James J. Foster MD</u>		
22c PHYSICIAN'S NAME (TYPE OR PRINT)			22d ADDRESS <u>916 19th NW Wash DC.</u>			22e DATE SIGNED OCT. 10, 1987			22f PHYSICIAN'S NAME (TYPE OR PRINT)		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b DATE OCT 14, 1987			23c NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEM			23d LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONTGOMERY MD		
24 FUNERAL DIRECTOR NAME 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901			25a DATE REC'D. BY REGISTRAR OCT 19 1987			25b REGISTRAR'S SIGNATURE <u>Julia Davis</u>			25c REGISTRAR'S NAME		

08012 OCT 20 97

Charles Francis Johnson

Philadelphia, Penna. 1900

My dear Mr. Johnson:
I have the pleasure to
acknowledge the receipt of
your letter of the 19th inst.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove page 4. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other final disposition of the body, the medical examiner must be notified of death.

BP

DHMH 16 60M 7'84
(VRA 15. 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR

REG. NO.

DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
Sarah S. Walker			October 9, 1987			11:35P.M.		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS (LAST BIRTHDAY))			IF UNDER 1 YEAR		
Female	Black	June 1, 1932	55 YRS.			MONTHS DATE HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH					
Md.	U.S.A.		Prince George's MD					
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Laurel	Greater Laurel Beltsville Hospital		Homemaker			Own Home		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE		
Md.	P.G.	Laurel				11690 S. Laurel Dr. 20708		
14 FATHER'S NAME (FIRST MIDDLE LAST)		15 MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)						
Henry Savoy		Alice Williams						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT				
No		215-44-5142		1755 Richfield Dr. ADDRESS				
				Jamie Walker-Severn, Md.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio pulmonary Arrest</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sever Cor. pulmonale</u>								
Conditions, if any, which gave rise to immediate cause (c) <u>Emphysema + Chronic Bronchitis</u>								
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Emphysema + Chronic Bronchitis</u>								
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes Mellitus I.D.</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION (CITY OR TOWN STREET CITY OR TOWN COUNTY STATE)				
22a. I certify that (I) (this hospital) attended the deceased from <u>10/5/87</u> 19 <u>87</u> to <u>10/9/87</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>10/9/87</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Revathy Murthy</u>		DEGREE <u>MBBS</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>10/12/87</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>REVATHY MURTHY</u>		22e. ADDRESS <u>6130, LANDOVER RD, LANDOVER, MD.</u>						
23a. (BURIAL) CREMATION, REMOVAL (SPECIFY)		23b. DATE <u>10/15/87</u>		23c. NAME OF CEMETERY OR CREMATORY <u>HARMONY MCH. PK.</u>		23d. LOCATION (CITY OR TOWN COUNTY STATE) <u>LANDOVER, P.G. MD.</u>		
24 FUNERAL DIRECTOR NAME <u>H. S. WASHINGTON + SONS</u>		ADDRESS <u>4925 BURNING WOOD AVE, N.E.</u>		25a. DATE REC'D. BY REGISTRAR <u>OCT 15 1987</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

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Journal
No. 1.0
Date 1.1.1987
U.S.A.
Journal
No. 1.0
Date 1.1.1987
U.S.A.
Journal
No. 1.0
Date 1.1.1987
U.S.A.

OCT 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 0 3 0 3

069334 OCT 22 1987

1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b HOUR	
Edward		Albert		Wallish				<input checked="" type="checkbox"/> MONTH		10/15		87				M	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (IN YEARS)		IF UNDER 1 YR		IF UNDER 24 HRS		7c DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Male	White	Aug. 9, 1943		44 YRS						10/15		87		A.		M	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH											
Pennsylvania		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Prince George's County										MD	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY											
Bowie		13406 Overbrook Lane		Systems Analyst		Vitro											
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS									
Maryland		Prince George's		Bowie		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13406 Overbrook Lane		20715							
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME															
Edward		J.		Wallish		Mary		M.		Valimskie							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS											
NO		185-34-2805		Patricia A. Wallish		13406 Overbrook Lane		Bowie, MD		20715							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		PART I DEATH WAS CAUSED BY		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				Multiple sclerosis.													
				(b)		DUE TO, OR AS A CONSEQUENCE OF											
				(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		None															
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY?													
None				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
		P.M. 19		None													
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f LOCATION													
				STREET		CITY OR TOWN		COUNTY		STATE							
22a I certify that I took charge of the remains described above, held an		Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/>		and in my opinion													
death resulted from		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
		M.D. Deputy		10/15/87													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
John S. Rogers, M.D.		Silver Spring, Montgomery County, MD															
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION		COUNTY		STATE							
Removal/Burial		OCT 24, 1987		St. Edward's Cemetery		Shamokin,		Pennsylvania									
24 FUNERAL DIRECTOR NAME		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE													
Beall Funeral Home		OCT 21 1987															
16000 Annapolis Road		Bowie, MD 20715-3043															

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1. DECEASED NAME (TYPE OR PRINT) BERNARD BENJAMIN WALZ			2a. DATE OF DEATH MONTH DAY YEAR 10/06/87			2b. HOUR 3:33 AM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 8 1907		6. AGE (IN YEARS LAST BIRTHDAY) 80		7. UNDER 24 HRS. MONTHS DAYS HRS. MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George			MD	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Prince George Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist		12b. KIND OF BUSINESS OR INDUSTRY Own Garage		
13a. STATE Maryland			13b. COUNTY Pr Geo		13c. CITY OR TOWN Upp Marlboro		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9115 Marlboro Pike #14 20772	
14. FATHER'S NAME FIRST MIDDLE LAST Bernard Walz			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie I Fisher							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO 577 10 2730			17. INFORMANT ADDRESS Frances Louise Walz Same as #13				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYPOXIC ENCEPHALOPATHY								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 DAYS		
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) ACUTE MYOCARDIAL INFARCTION								10 DAYS		
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a 1. ALZHEIMER'S DEMENTIA 2. PROSTATE CARCINOMA. 8										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 9/15/87 19 to 10/6 19 87 that (I) (we) lost saw the deceased alive on 10/5/87 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Michael York MD			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/6/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL F. YORK MD			22e. ADDRESS 5506 GREEN LANDING RD UPPER MARLBORO MD 20772							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 9 Oct 1987		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS Robert E Wilhelm Funeral Home Suitland Maryland						25a. DATE REC'D. BY REGISTRAR OCT 09 1987		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

BP

068877 OCT 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) ADDIE P. WASHINGTON			2a DATE OF DEATH MONTH DAY YEAR 10-10-87		2b HOUR 6 03AM	
3 SEX FEMALE		4 RACE BLACK		5 DATE OF BIRTH MONTH DAY YEAR OCT. 28, 1920		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA		7b CITIZEN OF WHAT COUNTRY? UNITED STATES		6 AGE (IN YEARS, LAST BIRTHDAY) 66 YRS MONTHS DAYS HOURS MIN		
10 CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S HOSPITAL CENTER		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD		
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CAR CLEANER		12b KIND OF BUSINESS OR INDUSTRY RAILROAD				
13a STATE MD		13b COUNTY WASHINGTON		13c CITY OR TOWN WASH., D.C.		
14 FATHER'S NAME FIRST MIDDLE LAST ROBERT BATTLE		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROBERTA WIGGINS				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b SOCIAL SECURITY NO 215 16 5522		17 INFORMANT ADDRESS PERCY BATTLE-Brother-1129 Chicago St., S.E. DC		

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
---	--	--	--

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 9B, PART 2 OR PART 3)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>9/29/87</u> 19 <u>87</u> to <u>10/10</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>10/9/87</u> 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <u>Alexander S. Pope</u>				DEGREE M.D.		22c DATE SIGNED	
22d PHYSICIAN'S NAME (TYPE OR PRINT) A. GHOSH M.D.				22e ADDRESS 6510 KENILWORTH AVE, SUITE 1400 RIVERDALE, MD. 20737			

23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE 10/17/87		23c NAME OF CEMETERY OR CREMATORY LINCOLN MEMORIAL CEMETERY		23d LOCATION (CITY OR TOWN) COUNTY STATE SUITLAND PG MARYLAND	
24 FUNERAL DIRECTOR NAME ADDRESS ALEXANDER S. POPE-2617 Pa Ave SE Wash, D.C.				25a DATE REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE OCT 16 1987 <u>Julia Sanders-Rodriguez</u>			

BP
DHMH 16 60M 7 B4
(VIA 15, 4)

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

068877 OCT 1961

OCT 8 1961

070528 NOV 28

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Cleveland Washington			2a. DATE OF DEATH MONTH DAY YEAR 10/17/87		2b. HOUR 5⁰⁰ AM
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR October 5, 1925		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD	
10. CITY OR TOWN OF DEATH CLINTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance	12b. KIND OF BUSINESS OR INDUSTRY Private	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) D.C.		13b. COUNTY Washington	13c. CITY OR TOWN Washington	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 713 Hamlin Street, N.E. 99947
14. FATHER'S NAME FIRST MIDDLE LAST Henry Washington			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Geraldine Unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO 216-24-0493	17. INFORMANT ADDRESS Cleveland Washington 6302 Hardwood Dr. LAITHAM, MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Septic shock UGI bleed DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Recurrent stroke & CVA DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus, Neuropathic					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE Clinton Washington MD	
22a. I certify that (I) (this hospital) attended the deceased from 10-16-87 to 10-17-87 that (I) (we) last saw the deceased alive on 10-16-87 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE [Signature] M.D.				22c. DATE SIGNED 10-17-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ABULHASAN U ANSARI M.D.				22e. ADDRESS 8926 Woodlawn Rd NE Clinton Md. 20735	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 23 October 87	23c. NAME OF CEMETERY OR CREMATORY Washington National Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Maryland
24. FUNERAL DIRECTOR NAME Frazier's Funeral Home 389 R.I. Ave, N.W. Wash. D.C.				25a. DATE REC'D. BY REGISTRAR OCT 30 1987	
				25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial/cremation.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

068797 OCT 16 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

30507

1. DECEASED NAME (TYPE OR PRINT)		2. DATE KNOWN OF DEATH EST. MATED		3. DATE OF DEATH MONTH DAY YEAR		4. DATE OF DEATH MONTH DAY YEAR		5. DATE OF DEATH MONTH DAY YEAR		6. DATE OF DEATH MONTH DAY YEAR		7. DATE OF DEATH MONTH DAY YEAR		8. DATE OF DEATH MONTH DAY YEAR		9. DATE OF DEATH MONTH DAY YEAR		10. DATE OF DEATH MONTH DAY YEAR		11. DATE OF DEATH MONTH DAY YEAR		12. DATE OF DEATH MONTH DAY YEAR		13. DATE OF DEATH MONTH DAY YEAR		14. DATE OF DEATH MONTH DAY YEAR		15. DATE OF DEATH MONTH DAY YEAR		16. DATE OF DEATH MONTH DAY YEAR		17. DATE OF DEATH MONTH DAY YEAR		18. DATE OF DEATH MONTH DAY YEAR		19. DATE OF DEATH MONTH DAY YEAR		20. DATE OF DEATH MONTH DAY YEAR		21. DATE OF DEATH MONTH DAY YEAR		22. DATE OF DEATH MONTH DAY YEAR		23. DATE OF DEATH MONTH DAY YEAR		24. DATE OF DEATH MONTH DAY YEAR		25. DATE OF DEATH MONTH DAY YEAR		26. DATE OF DEATH MONTH DAY YEAR		27. DATE OF DEATH MONTH DAY YEAR		28. DATE OF DEATH MONTH DAY YEAR		29. DATE OF DEATH MONTH DAY YEAR		30. DATE OF DEATH MONTH DAY YEAR		31. DATE OF DEATH MONTH DAY YEAR		32. DATE OF DEATH MONTH DAY YEAR		33. DATE OF DEATH MONTH DAY YEAR		34. DATE OF DEATH MONTH DAY YEAR		35. DATE OF DEATH MONTH DAY YEAR		36. DATE OF DEATH MONTH DAY YEAR		37. DATE OF DEATH MONTH DAY YEAR		38. DATE OF DEATH MONTH DAY YEAR		39. DATE OF DEATH MONTH DAY YEAR		40. DATE OF DEATH MONTH DAY YEAR		41. DATE OF DEATH MONTH DAY YEAR		42. DATE OF DEATH MONTH DAY YEAR		43. DATE OF DEATH MONTH DAY YEAR		44. DATE OF DEATH MONTH DAY YEAR		45. DATE OF DEATH MONTH DAY YEAR		46. DATE OF DEATH MONTH DAY YEAR		47. DATE OF DEATH MONTH DAY YEAR		48. DATE OF DEATH MONTH DAY YEAR		49. DATE OF DEATH MONTH DAY YEAR		50. DATE OF DEATH MONTH DAY YEAR		51. DATE OF DEATH MONTH DAY YEAR		52. DATE OF DEATH MONTH DAY YEAR		53. DATE OF DEATH MONTH DAY YEAR		54. DATE OF DEATH MONTH DAY YEAR		55. DATE OF DEATH MONTH DAY YEAR		56. DATE OF DEATH MONTH DAY YEAR		57. DATE OF DEATH MONTH DAY YEAR		58. DATE OF DEATH MONTH DAY YEAR		59. DATE OF DEATH MONTH DAY YEAR		60. DATE OF DEATH MONTH DAY YEAR		61. DATE OF DEATH MONTH DAY YEAR		62. DATE OF DEATH MONTH DAY YEAR		63. DATE OF DEATH MONTH DAY YEAR		64. DATE OF DEATH MONTH DAY YEAR		65. DATE OF DEATH MONTH DAY YEAR		66. DATE OF DEATH MONTH DAY YEAR		67. DATE OF DEATH MONTH DAY YEAR		68. DATE OF DEATH MONTH DAY YEAR		69. DATE OF DEATH MONTH DAY YEAR		70. DATE OF DEATH MONTH DAY YEAR		71. DATE OF DEATH MONTH DAY YEAR		72. DATE OF DEATH MONTH DAY YEAR		73. DATE OF DEATH MONTH DAY YEAR		74. DATE OF DEATH MONTH DAY YEAR		75. DATE OF DEATH MONTH DAY YEAR		76. DATE OF DEATH MONTH DAY YEAR		77. DATE OF DEATH MONTH DAY YEAR		78. DATE OF DEATH MONTH DAY YEAR		79. DATE OF DEATH MONTH DAY YEAR		80. DATE OF DEATH MONTH DAY YEAR		81. DATE OF DEATH MONTH DAY YEAR		82. DATE OF DEATH MONTH DAY YEAR		83. DATE OF DEATH MONTH DAY YEAR		84. DATE OF DEATH MONTH DAY YEAR		85. DATE OF DEATH MONTH DAY YEAR		86. DATE OF DEATH MONTH DAY YEAR		87. DATE OF DEATH MONTH DAY YEAR		88. DATE OF DEATH MONTH DAY YEAR		89. DATE OF DEATH MONTH DAY YEAR		90. DATE OF DEATH MONTH DAY YEAR		91. DATE OF DEATH MONTH DAY YEAR		92. DATE OF DEATH MONTH DAY YEAR		93. DATE OF DEATH MONTH DAY YEAR		94. DATE OF DEATH MONTH DAY YEAR		95. DATE OF DEATH MONTH DAY YEAR		96. DATE OF DEATH MONTH DAY YEAR		97. DATE OF DEATH MONTH DAY YEAR		98. DATE OF DEATH MONTH DAY YEAR		99. DATE OF DEATH MONTH DAY YEAR		100. DATE OF DEATH MONTH DAY YEAR	
1. DECEASED NAME (TYPE OR PRINT)		2. DATE KNOWN OF DEATH EST. MATED		3. DATE OF DEATH MONTH DAY YEAR		4. DATE OF DEATH MONTH DAY YEAR		5. DATE OF DEATH MONTH DAY YEAR		6. DATE OF DEATH MONTH DAY YEAR		7. DATE OF DEATH MONTH DAY YEAR		8. DATE OF DEATH MONTH DAY YEAR		9. DATE OF DEATH MONTH DAY YEAR		10. DATE OF DEATH MONTH DAY YEAR		11. DATE OF DEATH MONTH DAY YEAR		12. DATE OF DEATH MONTH DAY YEAR		13. DATE OF DEATH MONTH DAY YEAR		14. DATE OF DEATH MONTH DAY YEAR		15. DATE OF DEATH MONTH DAY YEAR		16. DATE OF DEATH MONTH DAY YEAR		17. DATE OF DEATH MONTH DAY YEAR		18. DATE OF DEATH MONTH DAY YEAR		19. DATE OF DEATH MONTH DAY YEAR		20. DATE OF DEATH MONTH DAY YEAR		21. DATE OF DEATH MONTH DAY YEAR		22. DATE OF DEATH MONTH DAY YEAR		23. DATE OF DEATH MONTH DAY YEAR		24. DATE OF DEATH MONTH DAY YEAR		25. DATE OF DEATH MONTH DAY YEAR		26. DATE OF DEATH MONTH DAY YEAR		27. DATE OF DEATH MONTH DAY YEAR		28. DATE OF DEATH MONTH DAY YEAR		29. DATE OF DEATH MONTH DAY YEAR		30. DATE OF DEATH MONTH DAY YEAR		31. DATE OF DEATH MONTH DAY YEAR		32. DATE OF DEATH MONTH DAY YEAR		33. DATE OF DEATH MONTH DAY YEAR		34. DATE OF DEATH MONTH DAY YEAR		35. DATE OF DEATH MONTH DAY YEAR		36. DATE OF DEATH MONTH DAY YEAR		37. DATE OF DEATH MONTH DAY YEAR		38. DATE OF DEATH MONTH DAY YEAR		39. DATE OF DEATH MONTH DAY YEAR		40. DATE OF DEATH MONTH DAY YEAR		41. DATE OF DEATH MONTH DAY YEAR		42. DATE OF DEATH MONTH DAY YEAR		43. DATE OF DEATH MONTH DAY YEAR		44. DATE OF DEATH MONTH DAY YEAR		45. DATE OF DEATH MONTH DAY YEAR		46. DATE OF DEATH MONTH DAY YEAR		47. DATE OF DEATH MONTH DAY YEAR		48. DATE OF DEATH MONTH DAY YEAR		49. DATE OF DEATH MONTH DAY YEAR		50. DATE OF DEATH MONTH DAY YEAR		51. DATE OF DEATH MONTH DAY YEAR		52. DATE OF DEATH MONTH DAY YEAR		53. DATE OF DEATH MONTH DAY YEAR		54. DATE OF DEATH MONTH DAY YEAR		55. DATE OF DEATH MONTH DAY YEAR		56. DATE OF DEATH MONTH DAY YEAR		57. DATE OF DEATH MONTH DAY YEAR		58. DATE OF DEATH MONTH DAY YEAR		59. DATE OF DEATH MONTH DAY YEAR		60. DATE OF DEATH MONTH DAY YEAR		61. DATE OF DEATH MONTH DAY YEAR		62. DATE OF DEATH MONTH DAY YEAR		63. DATE OF DEATH MONTH DAY YEAR		64. DATE OF DEATH MONTH DAY YEAR		65. DATE OF DEATH MONTH DAY YEAR		66. DATE OF DEATH MONTH DAY YEAR		67. DATE OF DEATH MONTH DAY YEAR		68. DATE OF DEATH MONTH DAY YEAR		69. DATE OF DEATH MONTH DAY YEAR		70. DATE OF DEATH MONTH DAY YEAR		71. DATE OF DEATH MONTH DAY YEAR		72. DATE OF DEATH MONTH DAY YEAR		73. DATE OF DEATH MONTH DAY YEAR		74. DATE OF DEATH MONTH DAY YEAR		75. DATE OF DEATH MONTH DAY YEAR		76. DATE OF DEATH MONTH DAY YEAR		77. DATE OF DEATH MONTH DAY YEAR		78. DATE OF DEATH MONTH DAY YEAR		79. DATE OF DEATH MONTH DAY YEAR		80. DATE OF DEATH MONTH DAY YEAR		81. DATE OF DEATH MONTH DAY YEAR		82. DATE OF DEATH MONTH DAY YEAR		83. DATE OF DEATH MONTH DAY YEAR		84. DATE OF DEATH MONTH DAY YEAR		85. DATE OF DEATH MONTH DAY YEAR		86. DATE OF DEATH MONTH DAY YEAR		87. DATE OF DEATH MONTH DAY YEAR		88. DATE OF DEATH MONTH DAY YEAR		89. DATE OF DEATH MONTH DAY YEAR		90. DATE OF DEATH MONTH DAY YEAR		91. DATE OF DEATH MONTH DAY YEAR		92. DATE OF DEATH MONTH DAY YEAR		93. DATE OF DEATH MONTH DAY YEAR		94. DATE OF DEATH MONTH DAY YEAR		95. DATE OF DEATH MONTH DAY YEAR		96. DATE OF DEATH MONTH DAY YEAR		97. DATE OF DEATH MONTH DAY YEAR		98. DATE OF DEATH MONTH DAY YEAR		99. DATE OF DEATH MONTH DAY YEAR		100. DATE OF DEATH MONTH DAY YEAR	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07-84
25M

BP
DHMH-17
(VR A15 ME (5))

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Acute Myocardial Dis.
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last
(b) Chronic Myocardial Dis.
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a DATE OF OPERATION
19b CONDITION FOR WHICH OPERATION WAS PERFORMED?
20 AUTOPSY?
YES ☐ NO ☒
21a EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d INJURY OCCURRED
WHILE ☐ NOT WHILE ☐
AT WORK AT WORK
21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)
21f LOCATION
STREET CITY OR TOWN COUNTY STATE

22a I certify that I took charge of the remains described above, held on Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE [Signature] TITLE (SPECIFY) M.D. Doc MEDICAL EXAMINER
EXAMINER'S NAME (TYPE OR PRINT) ADDRESS
DATE SIGNED Oct-12-1987

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b DATE 10-16-87 23c NAME OF CEMETERY OR CREMATORY Balto. Nat. 23d LOCATION CITY OR TOWN Balto COUNTY Md. STATE
24 FUNERAL DIRECTOR NAME James A. Morden & Sons ADDRESS 1701 Laurens 25a DATE REC'D. BY REGISTRAR OCT 15 1987 25b REGISTRAR'S SIGNATURE [Signature]

000707 OCT 10 05

WIND

WIND

WIND



OCT 15 1952

068095 OCT-87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 30508

REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

2a. DATE OF DEATH

MONTH

DAY

YEAR

2b. HOUR

EDNA

WEBSTER

10 2 87

8:17pm

3 SEX

Female

4 RACE

Black

5 DATE OF BIRTH

December 3, 1896

6 AGE (IN YEARS LAST BIRTHDAY)

90

YRS.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Virginia

7b. CITIZEN OF WHAT COUNTRY?

USA

8 MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

PRINCE GEORGES COUNTY

MD

10 CITY OR TOWN OF DEATH

CLINTON MD

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

SOUTHERN MARYLAND HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Domestic

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Virginia

13b. COUNTY

Arlington

13c. CITY OR TOWN

NONE

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE

1923 N. Dinwiddie Street 22207

14 FATHER'S NAME

Unknown

15 MOTHER'S MAIDEN NAME

Martha

MIDDLE

Webster

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

No

16b. SOCIAL SECURITY NO

223-40-0329

17 INFORMANT

ADDRESS

Martha King-Cousin 1923 N. Dinwiddie St. Arl.

18 CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c)

PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Coronary Artery

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

Possible Acute myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF
Hypertensive Heart Disease

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

AF - crp - 8/11/87 - 10/12/87

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED

(ENTER NATURE OF INJURY IN ITEM 21b. PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐AT WORK ☐ AT WORK ☐

21e. PLACE OF INJURY

(AT HOME STREET FACTORY OFFICE FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from

above, (I) (we) (we) (did not) view the body after death.

and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

22b. SIGNATURE

DEGREE

ATTENDING

MEDICAL

STAFF

PHYSICIAN ☐DIRECTOR ☐PHYSICIAN ☐

22c. DATE SIGNED

10/12/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

REZA MOSTAFAEI

22e. ADDRESS

4235 28th Ave Md 20745

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

10/7/87

23c. NAME OF CEMETERY OR CREMATORY

Lincoln Memorial Cem.

23d. LOCATION

Suitland, Maryland

24. FUNERAL DIRECTOR

NAME

Rupert B Baker

24b. ADDRESS

Chinnfuneral Va.

25a. DATE REC'D BY REGISTRAR

OCT 06 1987

25b. REGISTRAR'S SIGNATURE

Jana Gordon-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The line requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been completed by attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director must attach page 3 to the certificate and file it with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

BP

[Faint, illegible text, likely bleed-through from the reverse side of the page]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

30509

FOR
1- REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

Robert Alden Weimer, SR.

2a. DATE KNOWN OF DEATH
2b. MONTH DAY YEAR
2c. DATE PRONOUNCED DEAD
2d. HOUR MIN

3 SEX

M

4 RACE

W

5 DATE OF BIRTH

March 15 1923

6 AGE (IN YEARS)

33 YRS

IF UNDER 1 YR

IF UNDER 24 HRS

7a BIRTHPLACE

Pennsylvania

7b CITIZEN OF WHAT COUNTRY?

U.S.A.

8 MARRIED

NEVER MARRIED

9 BALTIMORE CITY OR COUNTY OF DEATH

Prince Georges MD

10 CITY OR TOWN OF DEATH

11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

12a USUAL OCCUPATION

12b KIND OF BUSINESS OR INDUSTRY

13a STATE

13b COUNTY

13c CITY OR TOWN

13d INSIDE CITY LIMITS?

13e STREET ADDRESS

14 FATHER'S NAME

15 MOTHER'S MAIDEN NAME

16a WAS DECEASED EVER IN U.S. ARMED FORCES?

16b SOCIAL SECURITY NO.

17 INFORMANT

18 CAUSE OF DEATH

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED?

20 AUTOPSY?

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

21a EXTERNAL CAUSE WAS

21b TIME OF INJURY

21c HOW INJURY OCCURRED

21d INJURY OCCURRED

21e PLACE OF INJURY

21f LOCATION

22a I certify that I took charge of the remains described above, held on

Autopsy

Inspection

Inquiry

and in my opinion

13a STATE

13b COUNTY

13c CITY OR TOWN

13d INSIDE CITY LIMITS?

13e STREET ADDRESS

14 FATHER'S NAME

15 MOTHER'S MAIDEN NAME

16a WAS DECEASED EVER IN U.S. ARMED FORCES?

16b SOCIAL SECURITY NO.

17 INFORMANT

18 CAUSE OF DEATH

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED?

20 AUTOPSY?

21a EXTERNAL CAUSE WAS

21b TIME OF INJURY

21c HOW INJURY OCCURRED

21d INJURY OCCURRED

21e PLACE OF INJURY

21f LOCATION

14 FATHER'S NAME

15 MOTHER'S MAIDEN NAME

16a WAS DECEASED EVER IN U.S. ARMED FORCES?

16b SOCIAL SECURITY NO.

17 INFORMANT

18 CAUSE OF DEATH

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED?

20 AUTOPSY?

21a EXTERNAL CAUSE WAS

21b TIME OF INJURY

21c HOW INJURY OCCURRED

21d INJURY OCCURRED

21e PLACE OF INJURY

21f LOCATION

Robert Alden Weimer

Elizabeth Erhardt

yes

WW-2

191-12-7255

Robert Weimer, Jr., Adelphi, Md.

9250 Edwards Way, Unit 702

Metastatic Carcinoma

Carcinoma of Prostate

None

None

16a WAS DECEASED EVER IN U.S. ARMED FORCES?

16b SOCIAL SECURITY NO.

17 INFORMANT

18 CAUSE OF DEATH

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED?

20 AUTOPSY?

21a EXTERNAL CAUSE WAS

21b TIME OF INJURY

21c HOW INJURY OCCURRED

21d INJURY OCCURRED

21e PLACE OF INJURY

21f LOCATION

yes

WW-2

191-12-7255

Robert Weimer, Jr., Adelphi, Md.

9250 Edwards Way, Unit 702

Metastatic Carcinoma

Carcinoma of Prostate

None

None

16a WAS DECEASED EVER IN U.S. ARMED FORCES?

16b SOCIAL SECURITY NO.

17 INFORMANT

18 CAUSE OF DEATH

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED?

20 AUTOPSY?

21a EXTERNAL CAUSE WAS

21b TIME OF INJURY

21c HOW INJURY OCCURRED

21d INJURY OCCURRED

21e PLACE OF INJURY

21f LOCATION

yes

WW-2

191-12-7255

Robert Weimer, Jr., Adelphi, Md.

9250 Edwards Way, Unit 702

Metastatic Carcinoma

Carcinoma of Prostate

None

None

16a WAS DECEASED EVER IN U.S. ARMED FORCES?

16b SOCIAL SECURITY NO.

17 INFORMANT

18 CAUSE OF DEATH

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED?

20 AUTOPSY?

21a EXTERNAL CAUSE WAS

21b TIME OF INJURY

21c HOW INJURY OCCURRED

21d INJURY OCCURRED

21e PLACE OF INJURY

21f LOCATION

yes

WW-2

191-12-7255

Robert Weimer, Jr., Adelphi, Md.

9250 Edwards Way, Unit 702

Metastatic Carcinoma

Carcinoma of Prostate

None

None

16a WAS DECEASED EVER IN U.S. ARMED FORCES?

16b SOCIAL SECURITY NO.

17 INFORMANT

18 CAUSE OF DEATH

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED?

20 AUTOPSY?

21a EXTERNAL CAUSE WAS

21b TIME OF INJURY

21c HOW INJURY OCCURRED

21d INJURY OCCURRED

21e PLACE OF INJURY

21f LOCATION

yes

WW-2

191-12-7255

Robert Weimer, Jr., Adelphi, Md.

9250 Edwards Way, Unit 702

Metastatic Carcinoma

Carcinoma of Prostate

None

None

16a WAS DECEASED EVER IN U.S. ARMED FORCES?

16b SOCIAL SECURITY NO.

17 INFORMANT

18 CAUSE OF DEATH

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED?

20 AUTOPSY?

21a EXTERNAL CAUSE WAS

21b TIME OF INJURY

21c HOW INJURY OCCURRED

21d INJURY OCCURRED

21e PLACE OF INJURY

21f LOCATION

yes

WW-2

191-12-7255

Robert Weimer, Jr., Adelphi, Md.

9250 Edwards Way, Unit 702

Metastatic Carcinoma

Carcinoma of Prostate

None

None

16a WAS DECEASED EVER IN U.S. ARMED FORCES?

16b SOCIAL SECURITY NO.

17 INFORMANT

18 CAUSE OF DEATH

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED?

20 AUTOPSY?

21a EXTERNAL CAUSE WAS

21b TIME OF INJURY

21c HOW INJURY OCCURRED

21d INJURY OCCURRED

21e PLACE OF INJURY

21f LOCATION

yes

WW-2

191-12-7255

Robert Weimer, Jr., Adelphi, Md.

9250 Edwards Way, Unit 702

Metastatic Carcinoma

Carcinoma of Prostate

None

None

16a WAS DECEASED EVER IN U.S. ARMED FORCES?

16b SOCIAL SECURITY NO.

17 INFORMANT

18 CAUSE OF DEATH

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED?

20 AUTOPSY?

21a EXTERNAL CAUSE WAS

21b TIME OF INJURY

21c HOW INJURY OCCURRED

21d INJURY OCCURRED

21e PLACE OF INJURY

21f LOCATION

yes

WW-2

191-12-7255

Robert Weimer, Jr., Adelphi, Md.

9250 Edwards Way, Unit 702

Metastatic Carcinoma

Carcinoma of Prostate

None

None

16a WAS DECEASED EVER IN U.S. ARMED FORCES?

16b SOCIAL SECURITY NO.

17 INFORMANT

18 CAUSE OF DEATH

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED?

20 AUTOPSY?

21a EXTERNAL CAUSE WAS

21b TIME OF INJURY

21c HOW INJURY OCCURRED

21d INJURY OCCURRED

21e PLACE OF INJURY

21f LOCATION

yes

WW-2

191-12-7255

Robert Weimer, Jr., Adelphi, Md.

9250 Edwards Way, Unit 702

Metastatic Carcinoma

Carcinoma of Prostate

None

None

16a WAS DECEASED EVER IN U.S. ARMED FORCES?

16b SOCIAL SECURITY NO.

17 INFORMANT

18 CAUSE OF DEATH

61 28 66 86 123 138

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

2a. DATE KNOWN OF DEATH		ESTIMATED DATE		MONTH		DAY		YEAR		HOUR	
10-21		19		87							
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS)		IF UNDER 1 YR		IF UNDER 24 HRS	
Male		White		11-8-14		73 YRS		MONTHS		DAYS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED		NEVER MARRIED		9 BALTIMORE CITY OR COUNTY OF DEATH			
OHIO		U.S.A.		WIDOWED		DIVORCED		PRINCE GEORGE		MD	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a USUAL OCCUPATION (TYPE OF WORK)		12b KIND OF BUSINESS					
LANHAM		Doctors Hospital		SALESMAN		ELECTRICAL APPLIANCES					
13a STATE		13b COUNTY		13c INSIDE CITY LIMITS		13d STREET ADDRESS					
Pa 15217		Pittsburgh		YES		2913 Shady Avenue					
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES?		16b SOCIAL SECURITY NO.		17 INFORMANT			
ALBERT		SADIE		NONE		167-03-5917		BURTON L. HIRSCH FUNERAL HOME 2704 MURRAY AVE.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
				Hypertensive Cardiovascular disease							
				(b)		DUE TO, OR AS A CONSEQUENCE OF					
				(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY?							
				YES		NO					
21a EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b TIME OF INJURY		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
		HOUR A.M. MONTH DAY YEAR									
21d EXTERNAL CAUSE WAS WHILE AT WORK OR NOT WHILE AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f LOCATION							
				CITY OR TOWN		COUNTY		STATE			
22a I certify that I took charge of the remains described above, held on death resulted from		Natural causes		Accident		Suicide		Homicide		Undetermined manner	
ACTUAL SIGNATURE		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED					
Augusto P. Rodriguez		Deputy				10-21-87					
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS									
Augusto P. Rodriguez, M.D.		5009 Rayburn Ct, Temple Hills, MD									
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION					
REMOVAL-BURIAL		10/22/87		poale zedeck memorial park-		RICHLAND TOWNSHIP, PA.					
24 FUNERAL DIRECTOR NAME		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE							
SOL LEVINSON & BROS., INC.		OCT 26 1987		J. Davidson-Randall							
6010 REISTERSTOWN RD., BALTO., MD 21215											

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

000000000000

10-21

10-21

10-21

10-21

10-21

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10-21

10-21

70068 OCT 29 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

30511

1- FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR PM		
1 DECEASED NAME FIRST MIDDLE LAST Emilie A. Wessells			Oct. 19, 1987			10:17 PM		
3 SEX Female			4 RACE Caucasian			5 DATE OF BIRTH MONTH DAY YEAR November 3, 1892		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia			7b CITIZEN OF WHAT COUNTRY? USA			6 AGE (IN YEARS LAST BIRTHDAY) YRS 94		
10 CITY OR TOWN OF DEATH Largo			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care Nursing Home			9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD		
12a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a STATE Maryland			12b KIND OF BUSINESS OR INDUSTRY own home			12c USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home maker		
13a COUNTY Pr. George's			13b CITY OR TOWN Lanham			13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST James Henry Allen			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Estelle Swift			13d STREET ADDRESS / ZIP CODE 5301 Lanham Station Road 20706		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			16b SOCIAL SECURITY NO. 219-54-9829			17 INFORMANT ADDRESS Emily A. Allen 5301 Lanham Station Road Lanham, Maryland 20706		
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF <u>Generalized Osteoporosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Deep Uleer</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Schistoma</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Year</u>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Schistoma</u>								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from <u>10-2-86</u> to <u>10-19-87</u> that (I) (we) lost saw the deceased alive on <u>10-19-87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b SIGNATURE <u>[Signature]</u>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <u>10-21-87</u>
22d PHYSICIAN'S NAME (TYPE OR PRINT) JOHANNES SAHAKIAN M			22e ADDRESS 5632 Annapolis Rd. Bowie, MD					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE OCT 22, 1987		23c NAME OF CEMETERY OR CREMATORY St. John's Epis. Ch. Cem. King George,		23d LOCATION CITY OR TOWN COUNTY STATE Virginia	
24 FUNERAL DIRECTOR NAME Beall Funeral Home			24b ADDRESS 16000 Annapolis Road Bowie, MD		25a DATE REC'D. BY REGISTRAR OCT 28 1987		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>	

069900 OCT 27 87

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										30512 REG. NO.	
1- FOR STATE REGISTRAR											
1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE KNOWN OF DEATH			2b HOUR		
Dan			White			10-6-87			M		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS)		IF UNDER 1 YR		IF UNDER 24 HRS	
Male		Black		10-1-14		73 YRS		MONTHS DAYS		HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED			9 BALTIMORE CITY OR COUNTY OF DEATH		
MISSISSIPPI			U.S.A.			NEVER MARRIED			Prince Georges MD		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a USUAL OCCUPATION (TYPE OF WORK)			12b KIND OF BUSINESS OR INDUSTRY		
CHEVERLY			Prince Georges General Hospital			LABORER			COMM. CENTER		
13a STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?		
D.C.						WASHINGTON			YES [X] NO []		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			16a WAS DECEASED EVER IN U.S. ARMED FORCES?			16b SOCIAL SECURITY NO.		
DAN			ANNA			YES [X] NO []			428-18-7137		
17 INFORMANT			18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		
EASTER WHITE			Diabetic arterial atherosclerotic cardiovascular disease								
832 52nd STREET N.E. WASHINGTON D.C.			PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1			20 AUTOPSY?					
			Harrison's Disease			YES [] NO [X]					
21a EXTERNAL CAUSE WAS UNDERLYING [] OR CONTRIBUTING [X] CAUSE OF DEATH			21b TIME OF INJURY			21c HOW INJURY OCCURRED			22a I certify that I took charge of the remains described above, held on		
			P.M. 19						Autopsy [] Inspection [X] Inquiry [X] and in my opinion		
21d INJURY OCCURRED WHILE [] NOT WHILE [X] AT WORK [] AT WORK [X]			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f LOCATION			22b death resulted from		
						CITY OR TOWN COUNTY STATE			Natural causes [X] Accident [] Suicide [] Homicide [] Undetermined manner []		
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION		
BURIAL			10-13-87			HARMONY CEMETERY			CITY OR TOWN COUNTY STATE		
24 FUNERAL DIRECTOR NAME			25 DATE RECEIVED BY REGISTRAR			26 MEDICAL EXAMINER'S SIGNATURE			27		
ROLLINS FUNERAL HOME, INC.			OCT 28 1987			Augusto P. Rodriguez, M.D.			DATE SIGNED 10-7-87		
4339 HUNT PLACE, N.E.											
WASHINGTON, D.C. 20019											

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN FIELD IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

07 84 BP
25M
DHMH - 17
(VR A15 ME (1))

068800 002701

10-10-50
10-10-50
10-10-50

10-10-50

10-10-50

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10-10-50

10-10-50

10-10-50

10-10-50

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRARDECEASED NAME
(TYPE OR PRINT)FIRST MIDDLE LAST
NATHAN AMOS WHITE2a DATE OF DEATH MONTH DAY YEAR 2b HOUR
Oct 30, 1987 2:00 am

3 SEX

Male

4 RACE

White

5 DATE OF BIRTH

MONTH DAY YEAR
Feb. 1 1908

6 AGE (IN YEARS, LAST BIRTHDAY)

79 YRS.

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Virginia

7b CITIZEN OF WHAT COUNTRY?

USA

8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Prince Georges MD

10 CITY OR TOWN OF DEATH

Hyattsville

11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

3904 Kennedy Street

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Ret. Auto Mechanic

12b KIND OF BUSINESS OR INDUSTRY

Triangle Ford

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

Maryland

Pr. Georges

13a CITY OR TOWN

Hyattsville

13d INSIDE CITY LIMITS?

YES ☒ NO ☐

13e STREET ADDRESS / ZIP CODE

3904 Kennedy St., 20781

14 FATHER'S NAME

(unknown)

15 MOTHER'S MAIDEN NAME

Lizzie

Souter

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

N/A

16b SOCIAL SECURITY NO.

578-10-0548

17 INFORMANT

Charles H. White-son- (same as 13e)

18 CAUSE OF DEATH Enter only one cause per line for a, b, and c.
PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Circulatory arrest

Less than 5 minutes

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

DUE TO OR AS A CONSEQUENCE OF

Deep Vein Thrombosis, left leg

2 weeks

DUE TO OR AS A CONSEQUENCE OF

Carcinoma Pancreas

1 month

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.

Chronic Obstructive Bronchopulmonary Disease

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

YES ☐ NO ☒

20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN VIEW OF PART 1 OR PART 2)

21d INJURY OCCURRED

21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f LOCATION (STREET)

CITY OR TOWN

COUNTY

STATE

22a I certify that (1) (this hospital) attended the deceased from Nov 8 19 84 to Oct 30 19 87 that (1) saw the deceased alive on Oct 29 19 87 and that in my opinion death occurred on the date and hour and from the causes stated

22b SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c DATE SIGNED

Oct 30, 1987

22d PHYSICIAN'S NAME (TYPE OR PRINT)

John F. Brennan, Jr. MD

22e ADDRESS

3415 Hamilton St., Hyatts., Md.

23a BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b DATE

Nov. 2, 1987

23c NAME OF CEMETERY OR CREMATORY

Fort Lincoln

23d LOCATION

Brentwood Pr. Georges Md.

24 FUNERAL DIRECTOR

Hines/Rinaldi Funeral Home 11800 N. H. Ave., Silver Spring, Md.

25a DATE REC'D BY REGISTRAR

NOV 3 1987

25b REGISTRAR'S SIGNATURE

Dorothy Rinaldi

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies, pages 1 and 2, and file them with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the funeral director must be notified at once.

100-100-100-100

100-100-100-100

100-100-100-100

100-100-100-100

100-100-100-100



100-100-100-100

068177 OCT

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

30515
REG NO

1- DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a DATE KNOWN OF DEATH	<input checked="" type="checkbox"/> MONTH	DAY	YEAR	2b HOUR
HORACE E. WHITNEY					ESTIMATED	<input type="checkbox"/>	10	7	1987
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE	IF UNDER 1 YR	IF UNDER 24 HRS	7c DATE PRONOUNCED DEAD	MONTH	DAY	YEAR
MALE	BLACK	NOV 22 1965	21 YRS			10	7	1987	6:30 AM
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED	NEVER MARRIED	WIDOWED	DIVORCED	9 BALTIMORE CITY OR COUNTY OF DEATH			
VIRGINIA	UNITED STATES	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prince George's County MD			
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY					
SUITHAND	street-3714 Branch Ave.	PORTER		PRIVATE					
13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET ADDRESS					
MARYLAND	PRINCE GEORGE	CAPITOL HEIGHTS	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	6616 RONALD ROAD 20743					
14 FATHER'S NAME	15 MOTHER'S MAIDEN NAME								
HORACE	ANN								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b SOCIAL SECURITY NO.	17 INFORMANT ADDRESS							
NO		ANN LOFTON-MOTHER-5121 FITCH ST SE DC							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple gunshot wounds (unspecified weapon)									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a) stating the under									
lying cause lost									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1									
19a DATE OF OPERATION									
19b CONDITION FOR WHICH OPERATION WAS PERFORMED?									
20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH									
21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR									
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK									
21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)									
21f LOCATION STREET CITY OR TOWN COUNTY STATE									
street 3714 Branch Ave. Prince George's MD									
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>									
22b TITLE (SPECIFY) Deputy Chief									
22c DATE SIGNED 10-7-87									
22d EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.									
22e ADDRESS 111 Penn St., Balto., MD 21201									
23a BURIAL, CREMATION, REMOVAL (SPECIFY)									
23b DATE 10-11-87									
23c NAME OF CEMETERY OR CREMATORY CROCKER FUNERAL HOME									
23d LOCATION CITY OR TOWN COUNTY STATE									
SUFFOLK, VIRGINIA									
24 FUNERAL DIRECTOR NAME ADDRESS									
ALEXANDER POPE-2617 PA AVE SE D.C.									
25a DATE REC'D. BY REGISTRAR OCT 8 1987									
25b REGISTRAR'S SIGNATURE Julia Danderson-Randall									

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DHMH - 17
(VR A15 ME (5))

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial/cremation, or as required by the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
FOR STATE REGISTRAR					REG. NO.						
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HENRY JOSEPH WILHELM					2a DATE OF DEATH MONTH DAY YEAR 09 30 87					2b HOUR 2 55PM M	
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR January 16, 1913		6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS		7b UNDER YEAR MONTHS DAYS HOURS MIN			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Dist. of Col.		7b CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD					
10 CITY OR TOWN OF DEATH CHEVERLY		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES HOSPITAL CENTER MD				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter		12b KIND OF BUSINESS OR INDUSTRY Construction			
13a USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD					13b COUNTY Charles		13c CITY OR TOWN Waldorf		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST Joseph Wilhelm					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Madeline Heizer					13e STREET ADDRESS / ZIP CODE Rt. 228, Box 177E 20601	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO WW II		17 INFORMANT Joan E. Bealle		ADDRESS Rt. 228, Box 177E Waldorf MD 20601					
18 CAUSE OF DEATH Enter only one cause per line for 18a, 18b, and 18c PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Hypocalcemia; Chronic Obstructive Pulmonary Disease</u>											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (1) this hospital attended the deceased from <u>8-20</u> 19 <u>87</u> to <u>9-30</u> 19 <u>87</u> that (2) I saw the deceased alive on <u>9-30</u> 19 <u>87</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death)											
22b SIGNATURE <u>Louis Sternberg</u>						DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10-1-87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Louis Sternberg						22e ADDRESS 6492 Landover Rd Landover, Md					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 10/05/87		23c NAME OF CEMETERY OR CREMATORY Maryland Veteran's Cemetery Cheltenham			23d LOCATION CITY OR TOWN COUNTY STATE			
24 FUNERAL DIRECTOR NAME The Hunt Funeral Home, Inc. P.O. Box 156 Waldorf MD 20601-0156						25a DATE REC'D. BY REGISTRAR OCT 05 1987		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CLAUDE PAUL WILLIAMS			2a DATE OF DEATH MONTH DAY YEAR OCTOBER 10 1987		2b HOUR 11:55 P
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR 09-16-22	6 AGE (IN YEARS LAST BIRTHDAY) 65 YRS	7b HOUR 11:55 P	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD		
10 CITY OR TOWN OF DEATH Military Install.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Andrews Air Force Base Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired - Air Force	12b KIND OF BUSINESS OR INDUSTRY	
13a STATE Maryland		13b COUNTY Queen Anne's	13c CITY OR TOWN Chestertown	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE Rt. 4 Box 532 21620
14 FATHER'S NAME FIRST MIDDLE LAST John Williams		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Bell Cotham			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Retired '63 489-28-9764	17 INFORMANT ADDRESS Edith Sparks Williams same as above			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>CARCINOMA OF THE HYPOPHARYNX</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE	
22a I certify that (a) (this hospital) attended the deceased from <u>24 SEPTEMBER</u> 19 <u>87</u> to <u>10 OCTOBER</u> 19 <u>87</u> that (b) (we) last saw the deceased alive on <u>10 OCTOBER</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <i>John A. Smith</i>		DEGREE MD		22c DATE SIGNED 11 OCT 87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) JOHN A. SMITH		22e ADDRESS MCMC, AAFB MD. 20331-5300		22f MEDICAL STAFF PHYSICIAN <input type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10/14/87	23c NAME OF CEMETERY OR CREMATORY Church Hill Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Church Hill Q.A. MD
24 FUNERAL DIRECTOR NAME Tom Helfenbein Funeral Home, Church Hill, MD 21623		25a DATE RECD BY REGISTRAR OCT 16 1987			
25b REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 60M 7/84
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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH30517
REG NO

1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE KNOWN OF DEATH			DATE ESTI MATED			2b HOUR		
JAMES WILLIAMS						7-?-87			19			M		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS)	IF UNDER 1 YR	IF UNDER 24 HRS	7c DATE PRONOUNCED DEAD			MONTH DAY YEAR			2d HOUR		
Male	Black	May 20, 1937	50 YRS			9-28-87			19			10:20a		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED			NEVER MARRIED			9 BALTIMORE CITY OR COUNTY OF DEATH		
Virginia			USA			WIDOWED			DIVORCED			Prince George's County MD		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY					
Accoheek			Livingston Road 15624			Mover								
13a STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?			13e STREET ADDRESS		
District of Columbia			Washington			YES X NO			4233 Barnaby Road, S.E. Apt 9999					
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			16a WAS DECEASED EVER IN U.S. ARMED FORCES?			16b SOCIAL SECURITY NO.			17 INFORMANT ADDRESS		
J.C. Williams			Ruth Stroble			yes			225 44 9371			Michelle Parran-daughter-6896 Walke		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														
PART I DEATH WAS CAUSED BY														
IMMEDIATE CAUSE (a) Shotgun wound of torso														
DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a) stating the under lying cause lost.														
(b)														
DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I														
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?									20 AUTOPSY?		
												YES X NO		
21a EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH			21b TIME OF INJURY			21c HOW INJURY OCCURRED								
X			HOUR A.M. MONTH DAY YEAR			subject found shot								
21d INJURY OCCURRED WHILE AT WORK			21e PLACE OF INJURY			21f LOCATION								
NOT WHILE AT WORK X			found in a wooded area			15624 Livingston Rd. Accoheek, Maryland								
22a I certify that I took charge of the remains described above, held an Autopsy X Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide X Undetermined manner														
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED								
Margarita A. Korell			Assistant			9-28-87								
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS											
Margarita A. Korell, M.D.			111 Penn Street											
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION					
Cremation			Oct. 13, 1987			Lee's Crematorium			Washington, D.C.					
24 FUNERAL DIRECTOR'S NAME			25a DATE REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE								
Stewart Funeral Home-4001 Benning Road, N.E.			OCT 16 1987			Julia Davidson-Randall								

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

 BP
DHMH - 17
(VR A15 ME (1))

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Virginia Elizabeth WILLIAMS			2a. DATE OF DEATH MONTH DAY YEAR October 16, 1987		2b. HOUR 7:28 P.M.
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR March 20, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.	IF UNDER 1 YEAR MONTH DAY YEAR
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
10. CITY OR TOWN OF DEATH Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	12b. KIND OF BUSINESS OR INDUSTRY G.S.A.	
13a. STATE D.C.		13b. COUNTY N/A	13c. CITY OR TOWN Washington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 4601 Jay St., N.E. 20019
14. FATHER'S NAME FIRST MIDDLE LAST Solomon Hill		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maggie Oates			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 579-09-7097		17. INFORMANT 8404 Thornberry Dr. W. Odie Williams, Jr. - Upper Marlboro Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIO Pulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Cerebro Vascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 8, PART 1, OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/16</u> 19 <u>87</u> to <u>10/16</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>10/16</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>RITA K. SHAM</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/17/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>RITA K. SHAM</u>		22e. ADDRESS 14333 Laurel Bowie Rd Laurel MD 20705			
23a. BURIAL CREMATION, REMOVAL (TYPE OR PRINT)	23b. DATE 10/21/87	23c. NAME OF CEMETERY OR CREMATORY HARMONY MEM. PARK		23d. LOCATION CITY OR TOWN STATE LANDOVER P.G. MD.	
24. FUNERAL DIRECTOR NAME H.S. WASHINGTON & SONS		ADDRESS 4925 BURROUGHS AVE. N.E.		25a. DATE OF DEATH OCT 22 1987	

MEDICAL CERTIFICATION

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

30517

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST IRIS T. WILSON			2a DATE OF DEATH MONTH DAY YEAR 10-7-87		2b HOUR 10:15 PM
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR 11 3 1907		6 AGE (IN YEARS LAST BIRTHDAY) 79 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? US	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD	
10 CITY OR TOWN OF DEATH Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Magnolia Gardens Nursing Home		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b KIND OF BUSINESS OR INDUSTRY ---
13a STATE Md.		13b COUNTY P. GEORGES	13c CITY OR TOWN Lanham	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST RICHARD TRAVIS TAYLOR		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EMMA I. WILLIAMS			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 218-16-7406-A		17 INFORMANT ADDRESS DIXIE RAIMOND - SAME AS 13a.b.c.d.e.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) URSEPSIS DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Multi-Infarct Dementia					
19a DATE OF OPERATION N/A		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED N/A	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE Crisfield Somerset Md.	
22a I certify that (I) (this hospital) attended the deceased from 8/27 , 19 87 , to 10-7 , 19 87 , that (I) (we) last saw the deceased alive on 10/7 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Don H. Yablonski		DEGREE MD		22c DATE SIGNED 10-7-87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Don H. Yablonski		22e ADDRESS 10300 Greenbelt Rd, Seabrook, Md			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10/10/87	23c NAME OF CEMETERY OR CREMATORY Sunnyridge Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Crisfield Somerset Md.
24 FUNERAL DIRECTOR NAME Bradshaw & Sons		ADDRESS Crisfield, Md. 21817		25a DATE RECD. BY REGISTRAR OCT 14 1987	
				25b REGISTRAR'S SIGNATURE John D. ...	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral home. It should be filed with the funeral home within 72 hours after death. The funeral home should be notified of the death of the deceased. The funeral home should be notified of the death of the deceased. The funeral home should be notified of the death of the deceased.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

BP

088081 OCT 13 67

SECRET

70558 NOV -3 87

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG NO 30520	
1- FOR STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT)				FIRST MIDDLE LAST		2a DATE KNOWN OF DEATH		2b HOUR	
		Lenora				Wimbish		DATE ESTI MATED 10-20 19 87		M	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS)		IF UNDER 1 YR		IF UNDER 24 HRS	
Female				4-16-28		59 YRS		MONTHS DAYS		HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED		NEVER MARRIED		9 BALTIMORE CITY OR COUNTY OF DEATH		10 HOUR	
North Carolina		USA		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				PG		MD	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY			
		Prince George Hospital				None					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE (CITY LIMITS?)		13e STREET ADDRESS			
Washington, D.C.						YES <input type="checkbox"/> NO <input type="checkbox"/>		635 Edgewood Street, N.E. Apt			
14 FATHER'S NAME						15 MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST						FIRST MIDDLE LAST					
Samuel Perry						Elнора Daniels					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS					
no				237 36 5428		Charlene Wimbish-daughter-5439 16th Ave					
18 CAUSE OF DEATH (Enter only one cause per the fact (a), (b), and (c).)											
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arterio pluvous cardiovascular disease</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) _____											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____											
MEDICAL CERTIFICATION											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
				P.M. 19							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Augusto P. Rodriguez</u>				Deputy				DATE SIGNED 10-20-87			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
Augusto P. Rodriguez, M.D.				5009 Rayburn Ct, Temple Hills, MD							
23a BURIAL, CREMATION, REMOVAL (SPECIFY)				23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE			
Burial				Oct. 24, 1987		Harmony Memorial Park		Landover, Maryland			
24 FUNERAL DIRECTOR NAME				ADDRESS		25a DATE REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Stewart Funeral Home				4001 Benning Road, NE.		NOV 02 1987		ina Davidson-Randall			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07 84
25MBP
DHMH - 17
(VR A15 ME (5))

0720 100-301

WINTER

WINTER

20% COTTON

WINTER



Chapman & Company

2007 N. 1st St., Suite 100, Lincoln, NE 68502

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 30521

FOR
1- STATE
REGISTRAR

REG. NO.

DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BERRY J WOOD 7a DATE OF DEATH MONTH DAY YEAR 10-9-87 7b HOUR 4.04 PM

3 SEX MALE 4 RACE White 5 DATE OF BIRTH MONTH DAY YEAR 8-18-1913 6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 12 HRS HOURS MIN.

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland 7b CITIZEN OF WHAT COUNTRY? U.S.A. 8 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD

10 CITY OR TOWN OF DEATH CLINTON 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MD. HOSP. 12a USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Real Estate Agent 12b KIND OF BUSINESS OR INDUSTRY Real Estate Co.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland 13b COUNTY Charles 13c CITY OR TOWN Hughsville 13d INSIDE CITY LIMITS? YES ☐ NO ☒ 13e STREET ADDRESS / ZIP CODE Rt.#1, Box 466/20637

14 FATHER'S NAME FIRST MIDDLE LAST Joshua -- Wood 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie Virginia Ferguson

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes 16b SOCIAL SECURITY NO. 213-02-8011 17 INFORMANT Berry J. Wood, Jr. 5906 Osbourne Rd., Upper Marlboro, Md. 20772

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RESPIRATORY ARREST APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) SEVERE CHRONIC OBSTRUCTIVE LUNG DISEASE

(c) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: SEVERE POSTERIOR EPISTAXIS, HYPERTENSION.

19a DATE OF OPERATION 19b CONDITION FOR WHICH OPERATION WAS PERFORMED 20a AUTOPSY? YES ☐ NO ☒ 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d INJURY OCCURRED 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f LOCATION (CITY OR TOWN) COUNTY STATE

22a I certify that (I) (the physician) attended the deceased from 9/27/87 19 to 10/9/87 19 that (I) was last saw the deceased alive on 10/9/87 19 and that (in my) own opinion death occurred on the date and hour and from the causes stated

22b SIGNATURE S. Mishra DEGREE M.D. ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c DATE SIGNED 10/11/87

22d PHYSICIAN'S NAME (TYPE OR PRINT) SANJEEB K. MISHRA M.D. 22e ADDRESS Suite # 508 Charles Center, Waldorf, Md.

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b DATE 10/14/87 23c NAME OF CEMETERY OR CREMATORY Resurrection Cemetery 23d LOCATION (CITY OR TOWN) COUNTY STATE Clinton (Pr. Geo's) Md.

24 FUNERAL DIRECTOR Richard A. Coleman Upper Marlboro, Md. 20772 25a DATE REC'D. BY REGISTRAR 25b RECEIVED OCT 19 1987

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

008661 OCT 30 87

11

OCT 19 87

068158 OCT-9-87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

30522
REG NO

1 DECEASED NAME (TYPE OR PRINT) Walter Edward Woolgar			7a DATE KNOWN OF DEATH ESTIMATED 10-6-87		7b HOUR M
3 SEX Male	4 RACE Caucasian	5 DATE OF BIRTH MONTH DAY YEAR 11/27/50	6 AGE (IN YEARS) (LAST BIRTHDAY) 36 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7c BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD		9 CITY OR TOWN OF DEATH Greenbelt		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Interstate 95, 1/4 mi. S. of BW Pkwy	
10 USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland		13b COUNTY P. G.		13c CITY OR TOWN Laurel	
13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS 231 Red Clay Rd #302 20707		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Parts Person	
12b BALTIMORE CITY OR COUNTY OF DEATH East West		12c BALTIMORE CITY OR COUNTY OF DEATH Lin. Mer. Auto		14 FATHER'S NAME FIRST MIDDLE LAST Frederick Woolgar	
15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Ireland		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No N/A		16b SOCIAL SECURITY NO. 213-56-0450	
17 INFORMANT Joyce L. Woolgar		ADDRESS Same as 13 A-E			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Shotgun wound of head</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
--	--	--

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7:30AM 10-6-87		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Self inflicted
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road		21f LOCATION CITY OR TOWN COUNTY STATE Interstate 95, 1/4 mi. S. of BW Pkwy.
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <i>Charles P. Kokes</i>		TITLE (SPECIFY) Assistant		DATE SIGNED 10-6-87
EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D.		ADDRESS 111 Penn Street, Balto., MD 21201		

23a BURIAL, CREMATION, REMOVAL (TYPE OF)	23b DATE 10/09/87	23c NAME OF CEMETERY OR CREMATORY St. James Episcopal Ch. Cem	23d LOCATION (CITY OR TOWN) COUNTY STATE Lothian Anne Arundel Md.
24 FUNERAL DIRECTOR NAME ADDRESS Lee Funeral Home, Inc. 6638 Old Alexander Ferry Rd Clinton, Md 20735		25a DATE REC'D BY REGISTRAR OCT - 8 1987	25b REGISTRAR'S SIGNATURE <i>Julia Henderson-Pandey</i>

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 1. RETAIN PAGE 5 AND YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07-84
25MDHMH - 17
(VR A15 ME)

088128 01-03

200% COTTON LIME

100% COTTON LIME

(015)

069126 OCT 20-87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

30323

1 DECEASED NAME (TYPE OR PRINT) DOROTHY FRANCES de CHANTAL WOODS			2a DATE OF DEATH MONTH DAY YEAR OCTOBER 13 1987		2b HOUR MIN 2:45P
3 SEX Female	4 RACE Caucasian	5 DATE OF BIRTH MONTH DAY YEAR July 6, 1908		6 AGE (IN YEARS LAST BIRTHDAY) 79	IF UNDER 1 YEAR MONTHS DAYS YRS
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's		
10 CITY OR TOWN OF DEATH Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bindery Worker		12b KIND OF BUSINESS OR INDUSTRY Printing
13a STATE Maryland			13b COUNTY Prince George's	13c CITY OR TOWN Bowie	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST Clarence Chaney		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Ellen Beall			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-16-1051		17 INFORMANT ADDRESS Norma T. Clark, Same as Line #13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral aneurysm DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) diffuse myelocystic infarct DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a stroke, renal failure, peripheral vascular disease					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (1) (this hospital) attended the deceased from 10/12 19 87 to 10/13 19 87 that (1) (we) last saw the deceased alive on 10/13 19 87 , and that in (my) (our) opinion, death occurred on the date and hour and from the causes stated above; (1) (we) (did) (did not) view the body after death					
22b SIGNATURE Dr. Charles		DEGREE		22c DATE SIGNED 10/13/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS CHANDLER		22e ADDRESS 4739 Lunnysville Dr. Berwyn Heights			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10-16-87		23c NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	
23d LOCATION (CITY OR TOWN) COUNTY STATE Brentwood, P.G., Maryland		24 FUNERAL DIRECTOR FRANCIS GASCHS SONS FUNERAL HOME, P.A.			
25a DATE BY REGISTRAR OCT 19 1987		25b REGISTRAR'S SIGNATURE Julia Davidson-Peterson			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 60M 7/84

(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

[Faint, illegible handwriting on lined paper, possibly bleed-through from the reverse side. The text is mostly mirrored and difficult to decipher.]